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No.

In the Supreme Court of the United States

OCTOBER TERM, 1996

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., *et al.*,
PETITIONERS,

v.

BRUCE M. BULLEN, *et al.*,
RESPONDENTS.

ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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10 pp

QUESTIONS PRESENTED

1. Whether, under this Court's decision in *Chevron* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984), a federal court, in deciding a case, may properly defer to a construction of a federal statute and regulations which an administrative agency has neither explicitly made, articulated nor explained, but which the court has inferred from the agency's action?

2. Whether a state complies with the state plan and public notice requirements set forth in the Medicaid statute and regulations for implementing new methods and procedures for determining provider reimbursement rates by filing a state plan amendment and publishing a public notice failing to contain any comprehensive description of the new methods and procedures, or the factors to be relied on in determining such rates?

3. Whether a state complies with the medical care advisory committee consultation requirements set forth in the Medicaid regulations for developing new Medicaid policies by consulting with such a committee only ten months after the new policies had already been implemented?

4. Whether a change from a wholly cost-based Medicaid reimbursement system to a system containing specified ceilings on allowable reimbursement rates constitutes a significant or material change within the meaning of the Medicaid statute and regulations requiring a state to file a state plan amendment, publish a public notice, and consult with a medical care advisory committee in implementing such changes?

LIST OF PARTIES

The plaintiffs below were petitioners Visiting Nurse Association of North Shore, Inc., Visiting Nurse Association of Boston, South Shore Visiting Nurse & Health Services, Inc., Brockton Visiting Nurse Association, Holyoke Visiting Nurse Association, Inc., VNA Homecare, Inc., Visiting Nurse Association of Greater Lowell, Inc., Visiting Nurse Association of Pioneer Valley, Inc., and Visiting Nurse Association of Central Massachusetts, Inc.[1]

The defendants below were respondents Bruce M. Bullen, in his capacity as the Commissioner of the Massachusetts Division of Medical Assistance, and Paula R. Griswold, Jonelle L. Snelling and Louis I. Freeman, in their capacities as members of the Massachusetts Rate Setting Commission.

[1] All of these entities are private, nonprofit corporations organized under the laws of the Commonwealth of Massachusetts. Visiting Nurse Association of North Shore, Inc. is a subsidiary of VNA Care Network; South Shore Visiting Nurse & Health Services, Inc. is a subsidiary of South Shore Health & Education, Inc.; Holyoke Visiting Nurse Association, Inc. is a subsidiary of Valley Health System; and Visiting Nurse Association of Pioneer Valley, Inc., is a subsidiary of Bay State Hospital.

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ON A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

TO THE HONORABLE, THE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

The petitioners respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the First Circuit, entered in the above-entitled proceeding on August 22, 1996.

OPINIONS BELOW

The opinion of the Court of Appeals for the First Circuit (CYR, J.) is reported at 93 F.3d 997 (1st Cir. 1996), and is reprinted in the Appendix hereto, p. A-1, *infra*. The opinion of the Court of Appeals for the First Circuit denying rehearing is not reported and is reprinted in the Appendix hereto, p. A-28, *infra*.

The Memorandum and Order of the United States District Court for the District of Massachusetts (GERTNER, D.J.) is reported at 866 F.Supp. 1444 (D. Mass. 1994), and is reprinted in the Appendix hereto, p. A-30, *infra*. The amended judgment of the United States District Court for the District of Massachusetts (GERTNER, D.J.) is not reported and is reprinted in the Appendix hereto, p. A-62, *infra*.

JURISDICTION

Invoking jurisdiction pursuant to 28 U.S.C. § 1331 and 42 U.S.C. § 1983, petitioners brought this action in the United States District Court for the District of Massachusetts. On May 26, 1995, judgment entered in the District Court holding that respondents' implementation on January 1, 1994 of new class reimbursement rates for providers of home health services to Medicaid patients was invalid by reason of the respondents' failure to comply with the state plan and public notice requirements set forth in applicable Medicaid regulations, but that respondents had validly implemented the rates as of November 1, 1994 as a result of their filing a new state plan amendment and publishing a new public notice, and, further, that their prior implementation of interim and phase-in rates was also valid. Respondents appealed to the United States Court of Appeals for the First Circuit from that part of the District Court's judgment that had held that their implementation of the class rates on January 1, 1994 was invalid; and petitioners cross-appealed from those parts of the District Court's judgment that had held that respondents' implementation of the class rates on November 1, 1994, and their earlier implementation of the interim and phase-in rates, were valid.

On August 22, 1996, the First Circuit reversed in part and affirmed in part the judgment of the District Court. Petitioners thereafter filed a petition for rehearing and suggestion of rehearing *en banc*. On September 13, 1996, the First Circuit denied this petition.

The jurisdiction of this Court to review the judgment of the First Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTE AND REGULATIONS INVOLVED

The statute and regulations involved are the federal Medicaid statute, 42 U.S.C. § 1396 *et seq.*, and various regulations promulgated thereunder, including 42 C.F.R. §§ 430.10, 430.12, 431.12, 447.201, 447.205 and 447.256. The pertinent text of these provisions is reprinted in the Appendix hereto, p. A-65, *infra*.

STATEMENT OF THE CASE

This case arises out of the implementation by defendants of new Medicaid reimbursement rates for providers of home health care services, including the nine plaintiffs. The federal Medicaid statute, 42 U.S.C. § 1396, establishes a joint federal-state program designed to afford medical benefits to low-income individuals. In order to participate in the program, a state must have submitted and "had approved" by the Secretary of Health and Human Services (the "Secretary") a plan for such participation including therein:

> "... such methods and procedures relating to ... the payment for care and services available under the plan ... as may be necessary ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

42 U.S.C. § 1396a(30)(A).

The Secretary has delegated her authority for administration of the Medicaid program to the Health Care Financing Administration ("HCFA"). HCFA, in turn, has promulgated

regulations providing that a state plan must be "a comprehensive written statement . . . describing the nature and scope of [the state's] Medicaid program" and must "contain all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program." 42 C.F.R. § 430.10. The regulations further provide that the state plan must "describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program." 42 C.F.R. § 447.201(b).

The Medicaid regulations additionally provide that, in the event that a state makes any "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program," the state must submit to HCFA a plan amendment "[s]o that HCFA can determine whether the plan continues to meet the requirements for approval." 42 C.F.R. § 430.12(c). A plan amendment which is approved by HCFA may be effective retroactive to the first day of the calendar quarter in which an "approvable" amendment was submitted to HCFA. 42 C.F.R. §§ 430.20 and 447.256.

In addition to submission of a plan amendment, the regulations further provide that a state "must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services." 42 C.F.R. § 447.205(a). Such notice, among other requirements, must (i) "[d]escribe the proposed change in methods and standards," and (ii) be published *prior* to the proposed effective date of the change. 42 C.F.R. § 447.205(c) and (d). The regulations also provide that a state must establish a medical care advisory committee ("MCAC"), including representatives of the health professions as well as Medicaid beneficiaries, and allow the MCAC an "opportunity for participation in policy development and program administration." 42 C.F.R. § 431.12(b) and (e).

Before 1991, Massachusetts described its rate-setting methodology to HCFA in its state plan only as "fixed negotiated fee schedules established by the Rate Setting Commission", when

in fact it was using a "cost-based" methodology to set rates for home health care providers, such as the plaintiffs.[2] In 1991, however, Massachusetts decided to convert its rate setting methodology to a so-called "class rate" system, whereby single state-wide rates would be established for each of the five basic services offered by the providers, including skilled nursing, occupational, physical, and speech therapy, and home-health aide services. In accordance with this decision, the respondent state officials implemented interim rates on July 1, 1991, phase-in rates on July 1, 1993, and, finally, state-wide class reimbursement rates on January 1, 1994.

At no time prior to implementing these interim, phase-in or class rates did the respondents file any state plan amendment with the Regional Administrator of HCFA describing the "methods and procedures" it had used to derive the class rates. While the respondents did publish a public notice on September 11, 1992, as required by 42 C.F.R. § 447.205(a), the notice stated only that the state would be adopting new regulations which would "change the structure of the reimbursement methodology to a class rate system." Neither the notice, nor the subsequent regulations implementing the phase-in and class rates, contained any explanation as to how the class rates were derived, or what factors were considered. Finally, the respondents did not at any time prior to implementation of the new rates consult with a MCAC, as required by 42 C.F.R. § 431.12(b) and (e).

In light of these and other deficiencies, the petitioners commenced the present action in January, 1994, alleging, among other things, that the interim, phase-in and class rates were all invalid because respondents had failed to comply with the procedural requirements set forth in the Medicaid statute and regulations for implementing such rates. Shortly thereafter,

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[2] Because the "cost-based" methodology was misdescribed in the state plan as "fixed negotiated fee schedules established by the Rate Setting Commission," there is no indication in the record that HCFA knew, prior to 1991, that the state was in fact using a cost-based reimbursement methodology.

in March, 1994, the respondents for the first time filed a state plan amendment ("SPA") with the Regional Administrator of HCFA ("SPA No. 94-003") which merely deleted the word "negotiated" from the plan description, and stated that providers of home health care services would be reimbursed for such services according to "fixed fee schedules established by the Rate Setting Commission." The amendment nowhere explained what the "fixed fee schedules" were, or the methods or procedures by which they had been developed. In June, 1994, the Regional Administrator, who had still not approved the class rates, requested that the Massachusetts Division of Medical Assistance ("DMA") submit further information to him regarding the amendment, including "the methodology or formula for the calculation of the fixed rate." The DMA made no response to this request.

In August, 1994, the District Court issued a decision holding that the class rates were invalid due to the respondents' failure to comply with the state plan and public notice provisions in the federal Medicaid regulations. The Court, however, declined to enter any injunction against the rates at that time, in order to give the respondents an opportunity to "cure" their various procedural violations and implement proper class rates.

In response to the District Court's decision, the respondents in September, 1994 published a new public notice, and in December, 1994 submitted a new plan amendment ("SPA No. 94-023") to the Regional Administrator of HCFA with a proposed effective date of November 1, 1994. Both the public notice and the new plan amendment provided a description of some of the factors which the state had considered in setting the new class rates, but still failed to disclose or explain how the rates had been derived. The respondents also for the first time convened a MCAC and consulted with it with respect to the new class rates.

Subsequently, in April, 1995, respondents submitted to the Regional Administrator of HCFA an amendment to SPA No. 94-003, which amendment merely incorporated and copied,

word for word, the text of SPA No. 94-023. Promptly thereafter, the Regional Administrator approved the amended SPA No. 94-003 retroactive to January 1, *1994*.

When the Regional Administrator took this action in April, 1995, he made no finding that the amendment had been in approvable form at the time it had first been submitted, in March, 1994. Nor did he make any finding that respondents had properly complied with the public notice and MCAC consultation requirements in implementing the class rates on January 1, 1994. Notwithstanding this, the First Circuit held, contrary to the District Court, that respondents' January 1, 1994 implementation of the class rates had been valid. In reaching this result, the Court of Appeals *assumed* that HCFA would not have approved SPA No. 94-003 retroactive to January 1, 1994, unless it had determined that SPA No. 94-003 was in "approvable" form at the time it was first submitted in March, 1994 since, under 42 C.F.R. § 447.256, a state plan amendment could not become effective earlier than the first day of a calendar quarter in which an "approvable" amendment was submitted. The Court stated: "HCFA itself implicitly determined that the phrase 'fixed fee schedules' met the section 1396(a)(30) mandate, otherwise it could not have approved Amendment 003 *retroactive to January 1, 1994.*" *See App.*, p. A-16, *infra*. The Court also stated that HCFA's approval prior to 1991 of the phrase "fixed negotiated fee schedules" as adequately describing the state's cost-based reimbursement methodology in effect at that time further suggested that HCFA interpreted the state plan regulations as requiring nothing more than a general description of the state's rate setting methodology. *Id.*, p. A-19, *infra*.

Purporting to rely on this Court's decision in *Chevron* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984) (*"Chevron"*), the Court then went on to conclude that HCFA's implicit interpretation of the state plan requirements contained in the Medicaid statute and regulations "arguably" served the purpose of the statute to permit the states "considerable flexibility in administering their respective Medicaid pro-

grams", and was not so unreasonable as to warrant "second-guessing" by the Court. *See* App., p. A-20, *infra*. The Court further stated that, since HCFA had implicitly found that SPA No. 94-003 was in "approvable" form as originally submitted, no further specificity of the methods and standards used by the state in setting reimbursement rates should be required in the state's public notice of such rates. Finally, the Court held that there was nothing in 42 C.F.R. § 431.12(e) which required consultation with a MCAC at any particular time, and that HCFA, in approving SPA No. 94-003 retroactive to January 1, 1994 might reasonably have concluded that respondents had complied with that regulation as well.

On the basis of the foregoing reasoning, the First Circuit concluded that the District Court's holding that the respondents had improperly implemented the class rates on January 1, 1994 should be reversed. The First Circuit then ruled that the rates as of November 1, 1994 were necessarily valid, because the rates were valid as of January 1, 1994. *See* App., p. A-26, *infra*.

The First Circuit also upheld the District Court's finding that respondents earlier implementation of the interim and phase-in rates had been valid. The Court said that "since we conclude, on the specific facts of this case, that deference is due HCFA's conclusion that a 'description' of 'methods and procedures' is adequate as long as it differentiates between a cost-based rate and a class rate system, we affirm the district court's finding that the interim and phase-in rates, which retained some aspects of the pre-1991 'cost-based' or 'negotiated' rate systems, did not represent a cognizable change in the methods and procedures such as necessitated a Plan amendment or public notice." *See* App., pp. A-26-27, *infra*.

REASONS FOR GRANTING THE WRIT

Your petitioners respectfully urge the Court to grant their Petition for Writ of Certiorari for two compelling reasons. First, the Court of Appeals' decision extends *Chevron* deference beyond any reasonable limits to purported agency "findings" neither articulated nor made, let alone explained. The Court cannot permit this to happen without causing any number of federal statutes and regulations to be misconstrued and misapplied, merely because a court wrongly assumes that an agency has made a reasoned policy decision about a matter, when in fact it has not.

Secondly, the Court should grant this Petition because the circuits are now deeply divided over the proper interpretation of the important state plan, public notice, and MCAC consultation requirements that Congress and HCFA have established for the adoption by a state of changes in its Medicaid reimbursement methodologies. Because of its unwarranted deference to implied "findings" of HCFA, the First Circuit adopted a construction of these provisions which is in conflict with several other circuits. It also held that a state could implement substantial changes in its reimbursement methodologies without complying with the state plan, public notice and MCAC consultation provisions at all. If these results are allowed to stand, they will render the important procedural provisions set forth in the Medicaid statute and regulations for setting new reimbursement rates essentially meaningless, to the serious detriment of the millions of providers and Medicaid beneficiaries affected by the program.

I. The Court Of Appeals' Deference To HCFA's Purported "Findings" In This Case Amounted To An Abdication Of Judicial Responsibility Calling For An Exercise Of This Court's Supervisory Powers

This Court has regularly held that, in construing ambiguous statutory language, a court should attempt to determine the statute's underlying purpose, and give effect to that purpose. *See* e.g., *Crandon* v. *United States*, 494 U.S. 152 (1990) (in determining meaning of statute court looks not only to the particular statutory language but also to the design of the statute as a whole and to its object and policy). In *Chevron* v. *Natural Resources Defense Council*, 467 U.S. 837 (1984), however, the Court created a substantial exception to this presumptive approach to statutory construction with respect to statutes creating administrative agencies. The Court held in *Chevron* that, where a statute creating an administrative agency is ambiguous with respect to an issue, and the agency charged with administering the statute adopts a construction that is reasonable, a federal court should defer to that construction rather than engage in its own analysis of the statute's underlying purpose. The stated rationale for the *Chevron* rule is that, where Congress has delegated policy making authority to an administrative agency, the extent of judicial review of the agency's "policy determinations [should be] limited." *Pauly* v. *Bethenergy Mines, Inc.*, 501 U.S. 680, 698 (1991).

Chevron has been cited in well over 1,000 cases, and has become one of the single most important decisions in the history of administrative law. K. Davis and R. Pierce, *Administrative Law Treatise*, § 3.2, at 110 (3rd ed. 1993). Because of Chevron's potential reach, and because it represents a critical exception to the normal rules of statutory construction, there is a clear need to restrict the decision to situations where it is properly applicable. Otherwise, courts easily might be misled by arbitrary agency action into misconstruing or misapplying a multitude of federal statutes and regulations. *See generally* Farina, *Statutory Interpretation And The Balance*

Of Power In The Administrative State, 89 Colum. L. Rev. 452 (1989) (questioning whether Court had gone too far in *Chevron* in mandating judicial deference to agency construction of a statute).

Accordingly, *Chevron* deference must be limited to actions or decisions which an agency has at least articulated and explained. If a court simply assumes that an agency has considered and decided a matter, the court may be wrong and there may, in fact, be no agency decision to which to defer. On the other hand, if a court infers or assumes an agency's policy rationale, it is likely to be the court itself, rather than the agency, that is making the policy choice. This is contrary to the essence of *Chevron,* and cannot be squared with any reasonable reading of it.

Consistent with the foregoing, this Court has held that a reviewing court should not infer from ultimate agency action that the agency has made specific findings with respect to a matter. *See Burlington Truck Lines* v. *U.S.*, 371 U.S. 156, 167-68 (1962) (agency must disclose the basis for its order so that reviewing court may determine whether agency has exercised its discretion with respect to a matter); *Phelps Dodge Corp.* v. *Labor Board,* 313 U.S. 177, 197 (1941) (An agency must "disclose the basis for its order" and give a "clear indication that it has exercised the discretion with which Congress has empowered it.") The Court has also held that a reviewing court "may not supply a reasoned basis for the agency's action that the agency itself has not given." *See Motor Vehicle Mfs. Ass'n* v. *State Farm Mut. Automobile Ins. Co.*, 468 U.S. 29, 43 (1983); *SEC* v. *Chenery Corp.*, 332 U.S. 194, 196 (1947); *see also Bowen* v. *American Hospital Ass'n,* 476 U.S. 610, 626 (1986) (Opinion of STEVENS, J.) ("Agency deference has not come so far that we will uphold regulations whenever it is possible to 'conceive a basis' for agency action."). The obvious reason for the foregoing rules is that, as stated above, if a reviewing court assumes that an agency has made findings which it has not articulated, the court may be mistaken. *See* K. Davis, *Administrative Law Treatise* § 16.07, at p. 456 (1st

ed. 1958) ("The obvious disadvantage of assuming that a general finding includes all specific findings necessary to support it is that the assumption may often be contrary to fact; the various reasons for requiring findings are subverted by the assumption."). Moreover, if a reviewing court supplies reasons for an agency's action which the agency itself has not given, it is the reviewing court, rather than the agency, that is making policy. See *Burlington Truck Lines* v. *U.S.*, 371 U.S. 156, 167 (1962) ("For the courts to substitute their . . . discretion for that of the [agency] is incompatible with the orderly functioning of the process of judicial review. . . . [T]he purpose of the rule is to avoid 'propel[ling] the court into the domain which Congress has set aside exclusively for the administrative agency.'")

In the present case HCFA made no finding at all that SPA No. 94-003 was in approvable form at the time it was first submitted in March, 1994, let alone provide reasons for any such finding. In approving the amendment in April, 1995 retroactive to January 1, 1994, the Regional Administration might simply have ignored or overlooked the limitation set forth in 42 C.F.R. § 447.256 that an amendment may be approved retroactive only to the first day of a calendar quarter in which an "approvable" amendment is submitted. Nor did HCFA make any explicit finding that the words "fixed negotiated fee schedules" had been adequate to describe the state's pre-1991 cost-based reimbursement system. In fact, from all that appears in the record, the Regional Director of HCFA did not know that the state was in fact operating a cost-based system prior to 1991, since the state had described its system as consisting only of "fixed negotiated fee schedules".

Notwithstanding the foregoing, the Court of Appeals inferred from the Regional Administrator's unexplained actions in this case that HCFA itself had adopted a construction of its regulations which permitted states to submit only terse descriptions of their specific reimbursement methodologies. The Court then made up its own policy rationale for this

implied construction — *i.e.*, permitting states to submit terse explanations of their reimbursement methodologies "arguably" served the statutory purpose of affording states substantial flexibility in adopting such methodologies, since it relieved them of the "cumbersome" administrative burden of submitting a new plan amendment every time they changed any significant part of their reimbursement formula. *See* App., pp. A-20-21, *infra*. This purported "explanation" on its face makes little sense, since requiring a state to describe the specific methods it has used to establish reimbursement rates is not unduly burdensome and has little or nothing to do with substantive flexibility. *See generally United States ex rel. Johnson* v. *Chairman of New York State Board of Parole*, 500 F. 2d 925, 930 (2d Cir. 1975) (requiring administrative agency to state reasons for its action does not interfere with exercise of discretion, but rather provides essential safeguard against arbitrary action); *see also Oklahoma Nursing Homes Ass'n* v. *Demps*, 816 F.Supp. 688, 698 & n.11 (W.D. Okla. 1992) (setting out examples of the type of detailed descriptions of reimbursement formulas that states have regularly been filing with HCFA). In any event, under the circumstances of this case, it is plain that the Court of Appeals was *not* examining a reason or explanation which HCFA itself had supplied for its actions, but rather was inventing its own speculative reason for HCFA's actions, and then deferring to HCFA's actions in reliance on the purported reason. This was plainly wrong, and was contrary to each of the decisions of this Court cited above. *See also Phelps Dodge Corp.* v. *NLRB*, 313 U.S. 177, 194-97 (1941) (to be sustained by reviewing court, agency must provide a reasoned explanation for its actions, and articulate with some clarity the standards that governed its decision.).[3]

[3] In its opinion, the Court of Appeals stated that it was required to speculate as to HCFA's reasons for taking its retroactive action in this case, since the petitioners had not named HCFA as a defendant in the action. *See* App., p. A-20, *infra*. In fact, however, petitioners had no reason to name HCFA as a defendant at the time the litigation was brought since, at that time, the respondents had not submitted any plan amendment to HCFA at all,

Similarly, with respect to the public notice and MCAC consultation requirements, the Court of Appeals simply speculated that HCFA would not require any more detail with respect to a new reimbursement methodology in a public notice than it would in a plan amendment, and that it would not require MCAC consultation prior to actual implementation of a new reimbursement methodology. The Court also speculated that HCFA would not have required any plan amendment or public notice at all when the state first implemented the interim and phase-in rates in this case, since the interim and phase-in rates contained "some aspects" of the earlier cost-based system. Once again, there was no basis for this speculation on the part of the Court of Appeals. HCFA itself had not articulated any such positions.

The Court of Appeals' grant of *Chevron* deference to HCFA's assumed positions in this case was thus plainly misconceived. There was no showing that the agency itself had focused on the particular issues involved, or had come to any reasoned conclusions with respect to them. Nor was there any statement by the agency itself, rather than the reviewing court, of the reasons for the actions taken by the agency. HCFA's actions, therefore, were not entitled to deference from the Court of Appeals at all, let alone the controlling deference the Court gave to it.[4] *See also Skidmore* v. *Swift*

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and HCFA had not approved any such amendment. It was not until April, 1995, after the litigation had been proceeding for more than a year and the District Court had declared SPA No. 94-003 inadequate as originally submitted, that HCFA took the unexpected and extraordinary action of approving a totally revised SPA No. 94-003 retroactive to January 1, 1994. Thereafter, it was only the Court of Appeals, and *not* the District Court, that attached any significance to this retroactive action.

[4] The Court of Appeals also ignored the well-settled principle that the case for judicial deference is "considerably less compelling with respect to agency positions that are inconsistent with previously held views." *Thomas Jefferson University* v. *Shalala*, 114 S.Ct. 2381, 2384 (1994). This principle was applicable in this case because, in prior cases, HCFA adopted positions that were inconsistent with the positions attributed to it by the Court of Appeals in this case. Thus, in *State* v. *Shalala*, 42 F.3d 395 (10th Cir. 1994), HCFA specifically found that a plan amendment was *not* in approvable form where, as here, it contained only a single line reference to new rates,

& Co., 323 U.S. 134, 140 (1945) (weight to be given to judgment of administrative agency in a particular case will depend on "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.").

In this case the First Circuit speculated that HCFA had adopted a specific construction of the Medicaid statute and regulations, made up its *own*, highly implausible reason as to why HCFA "might" have adopted such a construction, and then granted deference to HCFA's action on the ground that HCFA had more "expertise" in this area than the Court did. This is not reliance on agency "expertise"; it is abdication of judicial responsibility, and a turning of *Chevron* on its head. The Court should, therefore, grant this Petition to clarify the limits of judicial deference to assumed or implied agency findings, a matter of considerable uncertainty for the federal courts. Otherwise, *Chevron* may be misused, under the guise of allowing agencies to make appropriate policy choices, to wreak havoc with the proper construction of federal statutes and regulations. *See Motor Vehicle Mfrs. Ass'n* v. *State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 48 (1983), *quoting from, New York* v. *United States*, 342 U.S. 882, 884 (1952) ("Unless we make the requirements for administrative action strict and demanding, expertise, the strength of modern government, can become a monster which rules with no practical limit on its discretion."); see also 2 K. Davis, *Administrative Law Treatise* § 8.1, at p. 157 (2d ed. 1983) ("Administrative law in its present stage of development is retarded in the whole area of informal action. Probably most of the injustice in this area pertains to inadequate control of discretion . . . .").

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without giving any description of how those new rates had been determined. Similarly, in *N.C. Dep't of Human Resources* v. *U.S. DHSS*, 999 F.2d at 767 (4th Cir. 1993), HCFA found that a public notice was required when a state had implemented changes in its reimbursement methodology that were significantly less substantial than those implemented here.

II. The Court Of Appeals' Decision Raises Important Questions Of Federal Law On Which The Circuits Are Now Deeply Divided

A. *The Construction Of The State Plan Requirements Adopted By The First Circuit In This Case Disserves The Congressional Intent Of Requiring Meaningful Review By The Secretary Of A State's Reimbursement Methodology Prior To Its Implementation And Conflicts Sharply With Decisions In Other Circuits*

The First Circuit's deference to HCFA's purported construction of the Medicaid statute and regulations in this case caused it to minimize, indeed virtually eradicate, the important procedural protections set forth in the federal Medicaid statute and regulations for setting new reimbursement rates for providers of health services to Medicaid beneficiaries. As described above, the Medicaid statute, 42 U.S.C. §1396, provides that funds may be made available under the statute only to states which "have submitted, *and had approved by the Secretary*, state plans for medical assistance." 42 U.S.C. §1396 (emphasis added). The statute further provides that a state plan for medical assistance must include such "methods and procedures" relating to the payment for care and services available under the plan as may be necessary to "assure that [such] payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(30)(A).

While the words "methods and procedures" are nowhere defined in the statute, they must refer to the various factors a state has considered in setting reimbursement rates for providers of health care services to Medicaid patients, and how the state has used those factors to arrive at such rates,

rather than to a general description of the type of reimbursement system a state has adopted. *See* Preamble to HCFA's Medicaid regulations, 46 Fed. Reg. 47964, 47965 (Sept. 30, 1981) ("The term 'rate' generally refers to the dollar amount payable to facilities under the State's payment method. The rate is simply the result of the payment method."). Otherwise, and contrary to the clear intent of the statute, the Secretary would have no basis for conducting any meaningful review of a state's proposed new methods for determining reimbursement rates, since the Secretary would have no means of knowing what those methods were, or how they were proposed to be applied. *See generally Wilder* v. *Virginia Hospital Association*, 496 U.S. 498, 514 (1990) ("there would be no reason to require a state to submit assurances to the Secretary [that its rates are reasonable and adequate] if the statute did not require the state's findings to be reviewable in some manner by the Secretary.").

Consistent with the foregoing, the regulations promulgated by HCFA under the Medicaid statute specifically provide that state plans and plan amendments must contain "*all* [the] information necessary for HCFA to determine whether the plan can be approved [or continue to be approved] to serve as a basis for Federal financial participation (FFP) in the State program." 42 C.F.R. § 430.10 (emphasis added). The regulations further provide that state plans must "describe the policy and methods to be used in setting [the] payment rates for each type of service included in the State's Medicaid program." 42 C.F.R. § 447.201. In light of these regulations, all of the federal courts that have considered the matter, until the decision of the First Circuit here, have held that state plans and plan amendments must contain at least *some* exposition and explanation of the specific methodology a state has used to establish reimbursement rates for particular providers of health care services to Medicaid patients, although they have differed on the specific amount of such exposition and explanation.

For example, in *State* v. *Shalala*, 42 F.3d 395 (10th Cir. 1994), HCFA specifically found, contrary to the finding

attributed to it by the Court of Appeals in this case, that a plan amendment was *not* in approvable form where, as here, it contained only a single line reference to new rates, without giving any description of how those rates were determined.[5] In upholding this action by HCFA, the U. S. Court of Appeals for the Tenth Circuit first noted that:

> "HCFA has required by rule, though, that a state plan 'specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with § 430.10 of his chapter.' 42 C.F.R. § 447.252(b) (1993). A plan must be 'comprehensive' and contain 'all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.' " 42 C.F.R. § 430.10 (1993).

Shalala, 42 F.3d at 599.

The Court then stated that:

> "In making the finding that no methodology was set forth in SPA 89-18 or the state plan, the Administrator implicitly interpreted the regulations as requiring that a comprehensive description contain something more than the single sentence in question, which does not specify what cost report factors were used, how they were used, or whether they were the only factors considered."

Id.

Similarly, in *Oklahoma Nursing Home Ass'n* v. *Demps*, 816 F.Supp. 688 (W.D. Okla. 1992), *appeal dismissed without op.*, 9 F.3d 117 (10th Cir. 1993), the court recognized that, as a matter of law, the state plan must contain some basic information on how rates are set:

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[5] The plan amendment in question stated that the inflation adjustment was "[b]ased upon a review of Oklahoma cost report factors as reflected in the two most recently submitted cost reports." *Shalala*, 42 F.3d at 599.

> "Oklahoma's Plan stands in stark contrast to those of some other states which this Court has examined. Oklahoma's Methods and Standards document does not impose or even suggest any particular mathematical formula; it gives no indication of how the rates are actually computed. ... The Oklahoma Plan .... contains nothing which could reasonably be expected to inform the reader of the methods used to set the rate; and certainly does not satisfy the requirement that the plan 'specify comprehensively the methods' used to set the rate."

Id. at 697-698. *See also Homes for Aging Ass'n* v. *Medical Policy & Planning,* 60 F.3d 262, 269 (7th Cir. 1995) (failure to "specify comprehensively" reimbursement methods and standards renders state plan invalid); *Oregon Ass'n for the Aging, Inc.* v. *State Department of Human Resources,* 5 F.3d 1239 (9th Cir. 1993) (state Medicaid plan must specify the methods and standards used to set payment rates).

Notwithstanding the foregoing decisions, and the regulations HCFA itself has promulgated requiring that state plans and plan amendments contain *all* the information necessary for HCFA to determine whether the plan can be approved as a basis for federal financial participation, the First Circuit held that the plan amendment submitted by the state respondents in the present case (SPA No. 94-003) was in approvable form at the time it was first submitted in March, 1994, even though, at that time, it provided only that providers of home health services would be reimbursed according to unspecified "fixed fee schedules" established by the state's rate setting commission. This result is in substantial conflict with the analysis of the state plan requirements in the Seventh, Ninth and Tenth Circuits.

The effect of the Court of Appeals' decision in this case is that a state can comply with the state plan requirements set forth in the Medicaid statute and regulations for implementing new reimbursement rates simply by filing a one-line

description of its general reimbursement system and then, if HCFA gets around to asking for further information, by providing an amended document of entirely different scope and detail more than *fifteen months* later and after litigation had been commenced seeking to have the rates enjoined. This cannot be the kind of procedure Congress intended when it provided that, in order to participate in the Medicaid program, a state must have submitted, and "had approved by the Secretary", a plan for such participation containing, among other things, the methods and standards it would be using to establish payment rates for providers of services under the plan. *See* 42 U.S.C. §§1396, 1396a(30). To the contrary, the entire thrust of the Medicaid statute and regulations is that there be some meaningful review by the Secretary at or before the time new methods for determining reimbursement rates are announced, not fifteen months after the new methods have already been implemented.[6]

In fact, as Congress itself clearly recognized, such meaningful review by the Secretary of a state's proposed methods and procedures for setting new reimbursement rates is the only effective safeguard against purely arbitrary state action in this area. *See generally Wilder* v. *Virginia Hospital Association*, 496 U.S. 498, 514 (1990) (purpose of requiring state to provide assurance to Secretary that it has complied with statutory standards in adopting reimbursement rates is to put state on notice that it cannot adopt "any rates it chooses"). The federal courts themselves are obviously ill-equipped to become involved in the minutiae of setting appropriate rates for

[6] The respondents' actions in this case can be analogized to a plaintiff who purports to satisfy the statute of limitations by filing a one-line complaint in court within the required time frame, and then acting to amend such a "complaint" months, or even years, later, to state a proper claim. It would be readily apparent in such circumstances that the statute of limitations was not satisfied. *See, e.g., Baldwin County Welcome Center* v. *Brown*, 466 U.S. 147, 149 n.3 (1983) (amendment cannot relate back to date of original pleading under Rule 15(c) of Federal Rules of Civil Procedure, where original pleading failed to give defendant fair notice of "what the plaintiff's claim is and the grounds upon which it rests").

health care providers. *See, e.g., Colorado Health Care Ass'n* v. *Colorado Dep't of Social Services*, 892 F.2d 1158, 1169 n.9 (10th Cir. 1988) ("If such a change in patient population and concomitant need should be specifically addressed in a state's reimbursement rate, then the Secretary is the one to so determine.").

This Court should, therefore, grant this Petition to reconcile a serious conflict among the federal circuits, and provide needed guidance as to the basic purpose and effect of the state plan requirements set forth in the Medicaid statute and its implementing regulations. The ineluctable logic of the First Circuit's decision in this case is that the state plan requirements are essentially meaningless, contrary to the clear intent of Congress.

B. *The First Circuit's Construction Of The Public Notice And Medical Care Advisory Committee Consultation Requirements Set Forth In The Medicaid Statute And Regulations Is Also In Conflict With Decisions In Other Circuits*

As described above, the public notice regulation, 42 C.F.R. § 447.205(c), provides that the notice *must*, among other things, (1) describe the proposed change in the state's "methods and standards" for setting payment rates for services and (2) explain "why the agency is changing its methods and standards." The manifest purpose of these requirements is to ensure that any significant changes in a state's "methods and standards" for setting reimbursement rates are equitable and conform to the statutory mandates of "efficiency, economy and quality of care" by inviting public comment on those changes. *See* 42 C.F.R. § 447.200 (purpose of public notice requirements is to "implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy and quality of care"); *N.C. Dep't. of Human Resources* v. *U.S. DHHS*, 999 F.2d 767 (4th Cir. 1993) (public notice requirements mandated by Medicaid

regulations are "not burdensome" and "provide a reasonable method of ensuring that rate changes are equitable and conform to statutory mandates . . . "). This purpose plainly cannot be achieved unless the public notice contains sufficient detail as to how and why the state has arrived at its proposed rates so that service providers, Medicaid beneficiaries and other interested parties can comment *meaningfully* on the proposed new rates. Only then can the public notice achieve its intended purpose. *See, e.g., Connecticut Light & Power Co.* v. *NRC*, 673 F.2d 525, 530 (D.C. Cir.), *cert. denied*, 459 U.S. 835 (1982) ("If the notice of proposed rulemaking fails to provide an accurate picture of the reasoning that has led the agency to the proposed rule, interested parties will not be able to comment meaningfully upon the agency's proposals").

Similarly, the medical care advisory committee regulation, 42 C.F.R. § 431.12, plainly contemplates that a state will consult with a MCAC *before* it implements substantial new Medicaid policies, rather than after. Thus, the regulation provides that a MCAC must be given an opportunity to participate in policy "development", not just policy implementation. 42 C.F.R. § 431.12(c). A body such as a MCAC obviously cannot participate in policy development if it is not consulted until months after the policy has already been implemented, as happened here. *See Morabito* v. *Blum*, 528 F.Supp. 252, 264 (S.D.N.Y. 1981) ("[T]he only way that a medical care advisory committee can be given the 'meaningful participation' that is required by 42 C.F.R. § 431.12(e) is to consult with them *prior to* the action in question.")

Notwithstanding all the foregoing, the First Circuit held that the public notice involved in the present case was satisfactory even though it stated only that the "proposed amendments change the structure of the reimbursement methodology to a class rate system," and failed to contain any explanation at all as to why the class rate system was being implemented, or how it had been derived. It also held that MCAC consultation was sufficient "as long as it occurs before the final HCFA approval of the plan amendment," even

where that final approval comes, as in the present case, more than 15 months after the plan amendment had already been implemented. These results are in substantial conflict with the decisions reached by several other circuits and, indeed, by the First Circuit itself. *See, e.g., Florida Power & Light Co.* v. *U.S.*, 846 F.2d 765, 771 (D.C. Cir. 1988) (notice of proposed rulemaking must contain "sufficient factual detail and rationale for the rule to permit interested parties to comment meaningfully"); *Methodist Hospital* v. *Indiana Family and Social Services Administration*, 860 F.Supp. 1309, 1326-28 (N.D. Ind. 1994), *aff'd*, 91 F.3d 1026 (7th Cir. 1996) (notice of proposed new reimbursement methodology must contain a sufficient description to "specify the changes in the methodology in calculating reimbursement rates"); *Burgess* v. *Affleck*, 683 F.2d 596, 599 (1st Cir. 1982) ("Under the regulation, the MCAC should have the opportunity to consider and discuss the available alternative policies, not merely the chance to make minor suggestions concerning a single policy already adopted by the state."); *Morabito* v. *Blum*, 528 F.Supp. 252, 264 (S.D.N.Y. 1981) ("The cases are unanimous that, where consultation with the medical care advisory committee is required, the committee's input must be sought and received *before* the state action in question, and not after the fact.").

The First Circuit's decision thus creates a conflict among the circuits with respect to the public notice and MCAC consultation requirements as well. This Court should therefore grant this Petition to reconcile this conflict, and give needed guidance as to the meaning and effect of these important additional protections against arbitrary state action in this area.

C. *The First Circuit's Basis For Concluding That The Interim And Phase-In Rates Did Not Constitute A Sufficient Change From The Earlier Cost-Based System To Require Any State Plan Amendment, Public Notice Or MCAC Consultation Also Conflicts With Decisions In Other Circuits*

While it is true, as the Court of Appeals noted, that the interim and phase-in rates retained "some aspects" of the earlier cost-based system, they also incorporated substantial elements of the new class rate system. For example, the interim and phase-in rates for the first time limited each provider's rates to the weighted mean rate of the Health Service Area (HSA) in which the provider was located. Apparently recognizing that these interim and phase-in rates constituted a significant change in the state's reimbursement methodology, the respondents themselves published a public notice at the time they were implemented which specifically referenced 42 C.F.R. § 447, the Medicaid public notice regulation, but which, as described above, failed to contain any detailed description of the methods and standards the respondents had used to establish the interim and phase-in rates.

Notwithstanding the foregoing, the Court of Appeals held, once again in purported reliance on an assumed construction of the applicable regulations which HCFA had neither articulated nor explained, but which the Court nevertheless attributed to it, that neither the interim nor the phase-in rates constituted a sufficient change from the earlier cost-based system to require *any* public notice or any state plan amendment. The Court said that: "since we conclude, on the specific facts of this case, that deference is due HCFA's conclusion that a 'description' of 'methods and procedures' is adequate as long as it differentiates between a cost-based rate and a class rate system, we affirm the district court's finding that the interim and phase-in rates, which retained some aspects of the pre-1991 'cost-based' or 'negotiated' rate systems, did not

represent a cognizable change in the methods and procedures such as necessitates a Plan amendment or public notice." *See* App., p. A-26-27, *infra*.

Once again, the result reached by the Court of Appeals is in sharp conflict with the decisions of several other circuits. Each of these other circuits has held that a substantially lesser change in a state's reimbursement methodology than that effected by the interim and phase-in rates in this case required compliance with the state plan and public notice provisions contained in the Medicaid statute and regulations. *See, e.g., State* v. *Shalala*, 42 F.3d 595, 598-602 (10th Cir. 1994) (change in inflation adjustment constitutes significant change requiring notice); *N.C. Dep't of Human Resources* v. *U.S. DHHS*, 999 F.2d 767 (4th Cir. 1993) (exclusion of state-operated nursing facilities from a limitation previously applicable to all nursing homes within state constituted a significant change requiring notice); *Missouri Dept. of Social Services* v. *Sullivan*, 957 F.2d 542, 545 (8th Cir. 1993) (use of new inflation index constituted significant change requiring public notice); *but see Mississippi Hosp. Ass'n* v. *Heckler*, 701 F.2d 511, 522 (5th Cir. 1983) (state plan amendment eliminating reimbursement for legal fees incurred in challenging Medicaid policies was not a significant change requiring public notice).

The First Circuit's decision has thus created a substantial conflict among the federal circuits not only as to the meaning of the state plan, public notice and MCAC consultation requirements set forth in the Medicaid statute and regulations, but also as to when these procedural provisions apply. This Court should therefore grant this Petition to resolve this additional conflict as well. Otherwise, the First Circuit's decision will allow states to implement significant changes in their reimbursement methodologies without complying with the important procedural provisions contained in the Medicaid statute and regulations at all, contrary to the clear intent of Congress, and of HCFA itself, to provide effective procedural

safeguards against arbitrary state action in the operation of the Medicaid program.

CONCLUSION

For all the foregoing reasons, the Petition for Certiorari should be granted.

Respectfully submitted,

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United States Court of Appeals
For the First Circuit

No. 95-1849

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS, APPELLEES,
v.
BRUCE M. BULLEN, ET AL.,
DEFENDANTS, APPELLANTS.

No. 95-1999

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS, APPELLANTS,
v.
BRUCE M. BULLEN, ET AL.,
DEFENDANTS, APPELLEES.

APPEALS FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
[HON. NANCY GERTNER, *U.S. District Judge*]

CYR, BOUDIN AND STAHL,
Circuit Judges.

Douglas H. Wilkins, Assistant Attorney General, with whom *Scott Harshbarger*, Attorney General, and *William L. Pardee*, Assistant Attorney General, were on brief for appellants Bullen, et al.

Richard P. Ward, with whom *John H. Mason*, *Susan T. Nicholson* and *Ropes & Gray* were on brief for appellees Visiting Nurse Association of North Shore, Inc., et al.

August 22, 1996

CYR, *Circuit Judge*. Nine Massachusetts health care providers initiated this civil rights action under 42 U.S.C. § 1983, alleging substantive and procedural violations of the Medicaid Act, *see* 42 U.S.C. § 1396a(a)(30) ("Act"), by the named defendants, various officials of the Massachusetts Medicaid program. The district court granted partial summary judgment for plaintiffs, declaring defendants in noncompliance with certain procedural requirements relating to the establishment of reimbursement rates for health care services provided to Medicaid recipients. Defendants appealed. Plaintiffs cross-appealed a district court ruling dismissing their remaining claims. We reverse the district court judgment against defendants and dismiss the cross-appeal.

I
BACKGROUND

Medicaid is a joint federal-state program designed to afford medical benefits to low-income individuals. *See* 42 U.S.C. § 1396 *et seq.*; *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). A State which elects to participate in Medicaid is eligible to receive federal funds only if its State Plan is approved by the Federal Health Care Financing Administration ("HCFA").[1] Among the sixty-two criteria for HCFA approval, *see* 42 U.S.C. § 1396a(a)(1)-(62), is the so-called "equal access" clause:

> [A State plan for medical assistance must] provide such *methods* and *procedures* relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary

[1] Authority to administer the Medicaid program and promulgate implementing regulations has been delegated to HCFA, a constituent agency of the Department of Health and Human Services. *See* 42 U.S.C. § 1302; 49 Fed. Reg. 35,247, 35,249 (1984); *see also Elizabeth Blackwell Health Ctr. for Women* v. *Knoll*, 61 F.3d 170, 174 (3d Cir. 1995), *cert. denied*, 116 S.Ct. 816 (1996).

> utilization of such care and services and *to assure that payments* are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*

Id. § 1396a(a)(30) (emphasis added); 42 C.F.R. § 447.201(b) ("The plan must describe the policy and the methods to be used in setting payment rates for each type of service. . . .").

Massachusetts establishes its reimbursement rates through the Massachusetts Rate Setting Commission, with the approval of the Division of Medical Assistance of the Massachusetts Executive Office of Health and Human Services ("DMA"). *See* Mass. Gen. L. ch. 6A, §§ 32, 36. Before 1991, Massachusetts used a "cost-based" methodology for setting reimbursement rates, laconically described in its approved plan as "fixed negotiated fee schedules." Ostensibly, the term "negotiated" connoted an intent to calculate a different rate for *each* individual health care provider, based on its reported costs for delivering five different categories of medical services (skilled nursing, occupational, physical and speech therapy, and home-health-aide services) during the preceding fiscal year, adjusted for such uniform factors as inflation and allowing for incentive caps (e.g., to promote efficiency). *See* Mass. Regs. Code tit. 114.3, § 3.00.

In 1991, however, Massachusetts decided to convert its rate-setting methodology to a so-called "class rate" system. Rather than basing reimbursement rates on the individual health care provider's idiosyncratic costs for the previous year, DMA decided to propose a single, fixed reimbursement rate for each of the five medical services categories, *supra*, which would be applied across-the-board to all in-state health care providers, without regard to their individual costs. During the transition to the new "class rate" system, a series of "interim" and "phase-in" rates were to be utilized.

Under the Medicaid Act and regulations, a State must meet two conditions before instituting "material" or "significant" changes in its Medicaid program:[2] i.e., (1) submit a Plan amendment to HCFA for approval, *"describ[ing]"* the methods used to set rates under 42 U.S.C. § 1396a(a)(30), *see* 42 C.F.R. § 447.201(b) (emphasis added), and (2) provide public notice *"describing* the proposed change[s]" and "[e]xplain[ing] why [it] is changing its methods and standards," *see id.* § 447.205(c)(1), (3) (emphasis added).

During a thirty-month period beginning in June 1991, Massachusetts issued public notices relating to the proposed change, and published a series of regulations, setting forth the interim, phase-in, and final class rates in "bottom-line" dollar figures for each of the five medical service categories, without detailing the particular formula and factors used to arrive at the proposed "bottom-line" rate figures. Thereafter, DMA conducted a series of public meetings to explain the proposed changes to health care providers, including appellees, and other interested parties. On January 1, 1994, the final class rates took effect, superseding the interim and phase-in rates.

Plaintiffs soon filed this section 1983 action, alleging that the DMA commissioner and its members had violated various substantive and procedural requirements prescribed by 42 U.S.C. § 1396a(a)(30).[3] By way of procedural violations, the complaint alleged that the pre-January 1994 public notices

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[2] We accept, *arguendo*, defendants' concession that the conversion to a "class rate" system constituted a "significant" and "material" change.

[3] As substantive violations, plaintiffs first alleged that the State had adopted its new methodology solely for the impermissible purpose of limiting its financial outlays under the Medicaid program, contrary to 42 U.S.C. § 1396a. *See Amisub (PSL), Inc.* v. *Colorado Dep't of Social Servs.*, 879 F.2d 789, 800-01 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990). Second, plaintiffs alleged that the class rates arrived at under the new fixed-rate methodology were so arbitrary and unreasonably low that many health care providers would have no financial incentive to participate in the Massachusetts Medicaid program, thereby ensuring that "equal access" to needed medical services could not be provided to all low-income individuals in all geographical areas at the same level as the general population. *See* 42 U.S.C. § 1396(a)(30).

issued by defendants contained legally deficient "descriptions" of the proposed new methods and procedures, by failing to disclose the *formula* defendants used to arrive at either the interim, phase-in, or final class rates. The complaint further alleged that defendants failed to file an appropriate amendment to the Massachusetts Plan, "describing" the "material" changes in its reimbursement rate methodology. Plaintiffs moved for partial summary judgment on their two procedural claims.

Massachusetts filed a Plan amendment ("Amendment 003") with the HCFA regional office in March 1994.[4] The amendment indicated the proposed change from a cost-based to a "class rate" system by deleting a single word from the original Plan description: "fixed negotiated fee schedules" now became simply "fixed fee schedules." Although a Plan amendment is deemed approved unless HCFA acts within ninety days of its filing, *see* 42 C.F.R. § 430.16(a), HCFA tolled the ninety-day period by advising defendants that additional information was needed — *i.e.*, "the methodology or formula for the calculation of the fixed rate" — to enable a final approval determination. *See id.* § 430.16(a)(ii).

Prior to the time DMA responded to the HCFA request for information, and before any final HCFA decision on Amendment 003, the district court granted partial summary judgment for plaintiffs on their procedural claims, ruling that neither Amendment 003 nor defendants' pre-January 1994 public notices provided adequate detail on the proposed "methods and procedures" for calculating final class rates. *See Visiting Nurse Ass'n of N. Shore, Inc.* v. *Bullen*, 866 F.Supp. 1444, 1459-62 (D. Mass. 1994). The court concluded that these procedural lapses rendered the final class rates invalid, thus obviating any need to determine whether the proposed new methodology or rates reasonably ensured compliance

[4] Retroactive effect — to "the first day of the quarter," *viz.*, January 1, 1994 — is accorded any "*approvable* plan [amendment] . . . submitted to [the HCFA] regional office." 42 C.F.R. § 430.20(b) (emphasis added); *see also id.* § 447.256(c).

with the substantive requirement — "equal access" to medical care — imposed by section 1396(a)(30). *Id.* at 1462.

Without conceding any procedural lapse, defendants issued another public notice on September 23, 1994, containing a detailed description of the methodology used to calculate the "new" final class rates, which were to take effect on November 1, 1994. In December 1994, defendants filed a second Plan amendment with HCFA ("Amendment 023"), which provided the same level of detail as the September 24, 1994 public notice. Defendants then asked the district court to declare them in compliance with the procedural requirements of section 1396a(a)(30). Then, in April 1995, while Amendments 003 and 023 remained pending, HCFA was notified that defendants wished to revise and update Amendment 003 to include the detailed information contained in Amendment 023. Defendants thus sought to make any HCFA Plan-amendment approval fully retroactive to January 1, 1994, rather than October 1994. *See supra* note 4. Three days later, HCFA approved Amendment 003, as revised, retroactive to January 1, 1994.

The district court entered final judgment, based on four essential holdings. *Visiting Nurse Ass'n of N. Shore. Inc.* v. *Bullen*, No. 94-10123-NG (D. Mass. June 30, 1995). First, the court reaffirmed its August 1994 declaratory ruling that defendants' initial implementation of the final class rates on January 1, 1994 was invalid for failure to comply with the public notice and Plan amendment requirements of section 1396a(a)(30), and directed entry of its declaratory judgment *nunc pro tunc* (i.e., effective September 30, 1994), the date on which its initial stay of the judgment expired. *Id.*, slip op. at 2. Second, defendants were found to have been in compliance with the section 1396a(a)(30) procedural requirements as of November 1, 1994, after providing detailed descriptions of the new rate-setting methodology in their September 1994 public notice and in Amendment 023. *Id.* Third, the district court ruled that defendants had never violated the section 1396a(a)(30) public notice and Plan amendment requirements

relating to their pre-January 1994 imposition of the interim and phase-in rates, presumably because these transitional rates, unlike the final class rates, did not effect a "material" or "significant" change from pre-1991 "cost-based" methods and procedures. *Id.* at 2-3. Finally, the district court dismissed plaintiffs' remaining claims — alleging that the new final class rates violated the substantive requirements of the section 1396a(a)(30) "equal access" clause — since its decision invalidating the rates due to procedural defects rendered further decision on the alleged substantive violations unnecessary. *Id.* at 3.

II
DISCUSSION

A. *Standards of Review*

We review the grant of summary judgment *de novo*, to determine whether the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits, as well as any reasonable inferences therefrom, when viewed in the light most favorable to the nonmoving party, demonstrate that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *See McCabe* v. *Life-Line Ambulance Serv., Inc.*, 77 F.3d 540, 544 (1st Cir.), *petition for cert. filed*, 64 U.S.L.W. 3808 (U.S. May 29, 1996) (No. 95-1929).

Normally, we accord plenary review to the district court's statutory and regulatory interpretations. *See Nowd* v. *Rubin*, 76 F.3d 25, 26 n.1 (1st Cir. 1996). When a federal agency charged with administering a particular program interprets its own enabling statute, however, we engage in a two-tiered review:

> "First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly

> addressed the precise question at issue, the court does not simply impose its own construction on the statute, *as would be necessary in the absence of an administrative interpretation*. Rather, if the statute is silent or ambiguous with respect to a specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute."

Heno v. *FDIC*, 20 F.3d 1204, 1208-09 (1st Cir. 1994) (quoting *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984)) (emphasis added) (*"Chevron"*).

As a federal agency charged with administering the Medicaid program, *see supra* note 1, HCFA plainly is entitled to *Chevron* deference in its interpretations of the Act and the implementing regulations. *See North Carolina* v. *United States Dep't of Health and Human Servs.*, 999 F.2d 767, 769-70 (4th Cir. 1993) (noting that an HCFA interpretation of its own regulations is entitled to "considerable deference"); *Folden* v. *Washington State Dept of Social and Health Servs.*, 981 F.2d 1054, 1058 (9th Cir. 1992); *Missouri Dep't of Social Servs.* v. *Sullivan*, 957 F.2d 542, 544 (8th Cir. 1992). Indeed, when a federal agency has promulgated and published a regulation pursuant to its own enabling statute, we review its interpretation of that *regulation* under a standard even "more deferential ... than that afforded under *Chevron*" to the agency's interpretation of the Statute. *National Med. Enters.* v. *Shalala*, 43 F.3d 691, 697 (D.C. Cir. 1995); *e.g. Indiana Ass'n of Homes for the Aging, Inc.* v. *Indiana Office of Medicaid Policy and Planning*, 60 F.3d 262, 266 (7th Cir. 1995) (applying heightened deference to HCFA regulations); *see Thomas Jefferson Univ.* v. *Shalala*, 114 S.Ct. 2381, 2386 (1994) (deferring to HHS interpretation of Medicare regulation); *Stinson* v. *United States*, 508 U.S. 36, 44 (1993); *Johnson* v. *Watts Regulator Co.*, 63 F.3d 1129, 1134-35 (1st Cir. 1995); *see also Consarc Corp.* v. *United States Treasury Dep't*, 71 F.3d 909, 915 (D.C. Cir. 1995). "[P]rovided an agency's interpretation of its own regulation does not violate

the Constitution or a federal statute, it must be given 'controlling weight unless it is *plainly erroneous* or inconsistent with the regulation.'" *Stinson*, 508 U.S. at 44 (citation omitted) (emphasis added); *see Loma Linda Univ.* v. *Schweiker*, 705 F.2d 1123, 1126 (9th Cir. 1983) (noting that an HCFA interpretation of its own regulation is entitled to deference "if it is within the range of reasonable meanings the words permit").

B. *Defendants' Appeal*

Defendants appeal from that portion of the final judgment declaring them in violation of the section 1396a(a)(30) procedural requirements during the period January 1 through October 31, 1994. Defendants claim, alternatively, that (1) the procedural requirements imposed by section 1396a(a)(30) are not enforceable by health care providers, (2) even if enforceable, however, defendants violated neither procedural requirement cited by plaintiffs, (3) the district court abused its discretion in August 1994 by ruling that defendants had violated section 1396a(a)(30), rather than staying the district court proceedings while Amendment 003 remained pending before HCFA, or (4) the declaratory judgment entered by the district court granted retrospective relief barred by the Eleventh Amendment, *see* U.S. Const. amend. XI.

1. *Standing: Enforceable Rights*

Section 1983 enables a private action against a State official to vindicate federal statutory rights enforceable by the plaintiff. *See* 42 U.S.C. § 1983; *Albiston* v. *Maine Comm'r of Human Servs.*, 7 F.3d 258, 261 (1st Cir. 1993). Whether section 1396a(a)(30) creates "enforceable" procedural and substantive rights

> turns on "whether [it] was intend[ed] to benefit the putative plaintiff[s]." If so, the provision creates an enforceable right unless it reflects merely a "congressional preference" for a certain kind of conduct rather than a binding obligation on the governmental unit, or unless the interest the plaintiff asserts is " 'too vague and amor-

> phous'" such that it is "'beyond the competence of the judiciary to enforce.'"

Wilder, 496 U.S. at 509 (citations omitted).[5]

a) *Substantive Rights*[6]

Section 1396a(a)(30) arguably describes two distinct substantive "equal access" rights: the right to require a State medicaid program to use reimbursement "methods and procedures" which (1) will "safeguard against unnecessary utilization of such [medical] care and services and [] assure that payments are consistent with efficiency, economy, and quality care," and (2) are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30).

In *Wilder*, the Supreme Court held that comparable provisions of section 1396a(a)(13) ("the Boren Amendment") did create enforceable substantive rights for institutional health care providers. *See Wilder*, 496 U.S. at 520. Section 1396a(a)(13) mandates that the State Plan provide:

> (A) for payment ... of the *hospital* services, *nursing facility* services, and services in an *intermediate care facility* for the mentally retarded provided under the plan through the *use of rates* (determined in accordance

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[5] In January 1996, Congress enacted 42 U.S.C. § 1320-2 (a Medicaid Act provision will "not [] be deemed unenforceable because of its inclusion in a section ... requiring a State Plan or specifying the required contents of a State plan"), which overturned, in part, the Supreme Court decision in *Suter* v. *Artist M.*, 503 U.S. 347 (1992). Before § 1320a-2 was enacted, some commentators had suggested that *Suter's* rationale supplanted the traditional *Wilder* test. *But see, e.g., Albiston*, 7 F.3d at 262-63 (holding that *Suter* did not overturn *Wilder*, but merely superimposed an additional threshold test). Consequently, we assume that Congress intended that § 1320-2 serve to resurrect the *Wilder* test, with no *Suter* overlay.

[6] We address the enforceability of the § 1396a(a)(30) substantive requirements as a threshold issue because the district court judgment dismissed plaintiffs' substantive claims, albeit on other grounds. *See infra* Section II.B.2(b). Even though we find those other grounds infirm, we may uphold the district court ruling on any ground supported by the record. *See Four Corners Serv. Station, Inc.* v. *Mobil Oil Corp.*, 51 F.3d 306, 314 (1st Cir. 1995).

> with methods and standards developed by the State . . .) which the State *finds*, and *makes assurances* satisfactory to the Secretary, are *reasonable* and *adequate* to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have *reasonable access* . . . to inpatient hospital services of adequate quality.

42 U.S.C. § 1396a(a)(13) (emphasis added).

Every court that has considered whether the *Wilder* rationale likewise applies to the second "equal access" right described in section 1396(a)(30) has determined that health care providers were intended beneficiaries under both the Boren Amendment and section1396(a)(30), since health care providers, as payees, obviously are affected by substantive changes in State reimbursement schemes under Medicaid. *See, e.g., Arkansas Med. Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993); *Sobky* v. *Smoley*, 855 F.Supp. 1123, 1137-38 (E.D. Cal. 1994); *Oklahoma Nursing Home Ass'n* v. *Demps*, 792 F.Supp. 721, 727 (W.D. Okla. 1992); *Illinois Hosp. Ass'n* v. *Edgar*, 765 F.Supp. 1343, 1348-49 (N.D. Ill. 1991). Without citation to supporting authority, defendants nonetheless insist that section 1396(a)(30) and the Boren Amendment are distinguishable.

i) *Intended Beneficiaries*

The *Wilder* Court reasoned that because the Boren Amendment "establishes a system for reimbursement of providers and is phrased in terms benefiting health care providers . . . [in that] [i]t requires a state plan to provide for 'payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan,'" "[t]here can be little doubt that health care providers are the intended beneficiaries." *Wilder*,

496 U.S. at 510.[7] Defendants argue, however, that unlike the Boren Amendment, section 1396a(a)(30) does not list specific categories of health care providers (e.g., hospitals, nursing facilit[ies], and intermediate care facilit[ies]), hence it cannot be said that Congress *focused* on providers as section 1396a(a)(30) beneficiaries. We are not persuaded.

The *Wilder* Court first observed that the statute "is phrased in terms benefiting health care *providers*," and leaves "little doubt that health care *providers* are the intended beneficiaries," then proceeded to *illustrate* how the plain language of the Boren Amendment "establishes a system for reimbursement of providers" through its listing of specific types of health care providers. Nowhere did the Court indicate that the more general term "providers" would not suffice, however, or that a listing of specific types of providers is a *sine qua non* without which a congressional intent to benefit health care providers could not be inferred. As long as the two statutory provisions evince a congressional concern for preserving financial incentives to providers — by ensuring adequate reimbursement payment levels — providers are appropriately considered intended beneficiaries. *See Arkansas Med. Soc'y, Inc.*, 6 F.3d at 526.

(ii) *"Preference" or "Binding Obligation"*

Defendants argue that section 1396a(a)(30) articulates a more discretionary "access" standard than that in the Boren Amendment, and that the additional discretion thus conferred belies a congressional intendment to lay down any "binding obligations" on the State in section 1396(a)(30). *See Wilder*, 496 U.S. at 509. As defendants see it, the Boren Amendment (1) requires the State not only to meet the ultimate benchmark of providing comparable "access" to medical care, but also

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[7] Although Medicaid recipients also are intended beneficiaries under the "equal access" requirement as it affects the availability of their medical care, it is well settled that Congress may create more than one class of intended beneficiary. *See Freestone* v. *Cowan*, 68 F.3d 1141, 1150 n.10 (9th Cir. 1995) (citing *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 110 (1989); *Carelli* v. *Howser*, 923 F.2d 1208, 1211 (6th Cir. 1991)).

the preliminary obligation to make "findings" and "assurances," satisfactory to the Secretary, that State reimbursement rates can ensure reasonable and adequate access, as well as comply with "State and Federal laws, regulations, and quality and safety standards," and (2) limits the potential reimbursement methods and procedures that the State can employ to the institution of "rates," rather than permitting more innovative or *ad hoc* reimbursement systems that might be less rate-dependent. We find no indication that the *Wilder* holding turned on these considerations.

First and foremost, the Boren Amendment and section 1396a(a)(30) are prefaced with the same mandatory language — [a] State plan for medical assistance *must* . . . [p]rovide," 42 U.S.C. § 1396a(a); *see Edgar*, 765 F.Supp. at 1349 — and the "reasonable" and "equal" access requirements upon which federal Medicaid funding depends, *see* 42 U.S.C. § 1396c, are conditions precedent to an approvable State Plan. *See Wilder*, 496 U.S. at 511 (contrasting with statute in *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 24 (1981), where hortatory language did not make "compliance with the provision a condition of receipt of federal funding"); *Arkansas Med. Soc'y, Inc.*, 6 F.3d at 526; *see also supra* note 5 (discussing newly enacted 42 U.S.C. § 1320a-2). Thus, the mandatory language in section 1396a(a) defies fair characterization as a mere "congressional preference."

Second, the majority opinion in *Wilder* mentioned the Boren Amendment requirement that there be "findings" and "assurances" merely to rebut a suggestion in the *Wilder* dissent that Congress had intended to accord plaintiffs standing to assert a judicial challenge to a State's default on these two procedural obligations, but not to challenge a substantive default (i.e., a State's adoption of rates that do not ensure "reasonable access," or that are not "adequate" to compensate "efficient[]" provider costs). *See Wilder*, 496 U.S. at 514 ("We reject that argument because it would render the statutory requirements of findings and assurances, and thus the entire reimbursement provision, essentially meaningless [since] . . .

[i]t would make little sense for Congress to require a State to make findings without requiring those findings to be correct."). The premise that procedural rights normally exist only as aids to the enforcement of substantive rights is not interchangeable with the proposition that substantive rights cannot exist absent an express provision of attendant procedural rights. Thus, the majority opinion in *Wilder* in no sense suggests that the Boren Amendment's substantive "access" requirement would have been found any less mandatory if, like section 1396(a)(30), it had contained no explicit procedural requirement of "findings" and "assurances."

iii) *Judicial Enforceability*

Defendants intimate, however, that absent any requirement of "findings" and "assurances," section 1396a(a)(30) is less amenable to effective judicial enforcement than the Boren Amendment. As we have explained, however, substantive requirements are not "impermissibly vague simply because [they] require[] judicial inquiry into 'reasonableness,'" or "adequate rates," as long as "the action or purpose whose 'reasonableness' [or 'adequacy'] is commanded has been clearly delineated and is susceptible of judicial ascertainment." *Albiston*, 7 F.3d at 267 (collecting cases).

The Boren Amendment and section 1396a(a)(30) contain nearly identical substantive requirements that the rates, or methods and procedures, used to determine reimbursements to health care providers ultimately ensure reasonable, adequate or equal "access" to medical care, which the Supreme Court in *Wilder* decided did *not* constitute a standard too vague or amorphous for judicial enforcement. *See Wilder*, 496 U.S. at 515 ("[T]he statute imposes the concomitant obligation to adopt reasonable and adequate rates."). Indeed, the term "equal access," as employed in section 1396a(a)(30), arguably provides a more concrete standard, objectively measurable against the health care access afforded among the general population, whereas the Boren Amendment employs the somewhat less objective benchmark: "reasonable" access.

Nor do we discern a material distinction between the focus on "methods and procedures" required by section 1396(a)(30) and the focus on "rates" required by the Boren Amendment. In either instance, the required determination — as to whether the State methods or procedures, or the resultant rates of reimbursement, are adequate to ensure "access" — is neither more nor less daunting a judicial task. *See id.* at 519 (noting that although States have great flexibility in choosing among a broad "range of reasonable rates," "the statute and regulation[s] set out factors which a State must consider in adopting its rates," so that "there certainly are some rates outside that range that no State could ever find to be reasonable and adequate under the Act.").[8]

For the foregoing reasons, therefore, we conclude that plaintiffs possess standing to enforce the substantive section 1396a(a)(30) requirement that the State adopt "methods and procedures" which will afford "equal access" to medical care as defined in section 1396a(a)(30).

b) *Procedural Rights*

Plaintiffs further contend that section 1396a(a)(30), as interpreted and applied through the HCFA implementing regulations, establishes two coincident procedural requirements designed to ensure that health care providers may enforce the substantive right of "equal access": the requirements that the State file a Plan amendment and a public notice "describing" its proposed new "methods and procedures" in some detail. Since we conclude that defendants

[8] We reject the implicit suggestion by defendants that the absence of a "findings" and "assurances" requirement under § 1396a(a)(30) makes meaningful judicial review wholly impracticable in that the courts have no factual bases for ascertaining whether the State's chosen "methods and procedures" satisfy the substantive "equal access" requirement. Setting aside the question whether the § 1396a(a)(30) implementing regulations afford any procedural rights that ensure disclosure, *see infra* Section II.B.2(a), plaintiffs may adduce evidence concerning the inadequacy of the State's selected methods and procedures, or flaws in the State's substantive decision-making processes, in any number of ways; for example, with information acquired by or from the State during public hearings, in proposed Plan changes, or in the published State regulations.

have not violated these procedural requirements, *see infra* Section II.B.2(a), we need not reach the enforceability issue.[9]

2. *Claimed Violations of Enforceable Rights*

a) *Procedural Rights*

i) *Plan Amendment 003*

Prior to the time Amendment 003 was submitted to HCFA in March 1994, the approved Massachusetts Plan described its "methods and procedures" for reimbursing providers as "fixed negotiated fee schedules." Amendment 003 purportedly altered the "methods and procedures" to be employed under the new class rate system simply by deleting the word "negotiated," with the result that the new rates were to be based on "fixed fee schedules."

Plaintiffs argue that the cryptic phrase "fixed fee schedules" is patently deficient to describe the proposed change in the Massachusetts reimbursement "methods and procedures," and that under whatever conceivable definition the phrase might be given, it utterly failed to notify HCFA or plaintiffs that defendants planned to change from a cost-based system to a class rate system, or to explain with any precision the methodology or formula defendants used to arrive at the bottom-line reimbursement figures announced in the DMA regulation. *See* Mass. Regs. Code tit. 114.3, § 3.04(4). We do not agree.

First, HCFA itself implicitly determined that the phrase "fixed fee schedules" met the section 1396a(a)(30) mandate, otherwise it could not have approved Amendment 003 *retroactive to January 1, 1994. See supra* note 4. In order to be entitled to retroactive effect to January 1, 1994, Plan amendment 003 had to have been "approvable" *as submitted in March 1994*, when it contained merely the three-word description presently challenged by plaintiffs as insufficient to satisfy section 1396a(a)(30).[10] We must therefore review the

[9] We likewise reserve judgement as to whether, and what extent, procedural rights prescribed only in the implementing regulations, rather than directly by statute, may be enforced in a § 1983 action. *See, e.g., Oklahoma Nursing Home Ass'n*, 792 F.Supp. at 725-26.

[10] Thus viewed, the HCFA interpretation comports with 42 C.F.R. § 30.16(a)(ii), which empowers HCFA to ask the State for any "additional

implicit interpretation given section 1396a(a)(30) by HCFA in this case.

At its initial stage, *Chevron* review accords no deference to the interpretation an agency gives to its enabling statute. *See supra* Section II.A. If the reviewing court independently determines that the intent of the statute is clear, as disclosed in its plain language and design, the statutory language is to be given full effect. *See Grunbeck* v. *Dime Sav. Bank of N.Y., FSB*, 74 F.3d 331, 340-41 (1st Cir. 1996); *Strickland* v. *Commissioner of Me. Dep't of Human Servs.*, 48 F.3d 12, 16-17 (1st Cir.), *cert. denied*, 116 S.Ct. 145 (1995).

Section 1396a(a)(30) mandates that a State Plan provide "methods and procedures relating to . . . the payment for [] [medical] care and services." Plaintiffs argue that "methods" has a plain or acquired meaning that necessitates disclosure of the formula the State used to arrive at its proposed bottom-line reimbursement figures. Thus, plaintiffs suggest that the solitary statutory term "rates" might permit a Plan amendment to list only bottom-line figures, *cf.* 42 U.S.C. § 1396a(a)(13), but that the presence of the term "methods" forecloses such an approach. Once again, we are unable to agree.

Even if the distinction suggested by plaintiffs were deemed sound, the question would remain: with what degree of specificity or detail must a State describe the methodology used in its Plan amendment? In this case, for example, although nonexhaustive, the terms "cost-based" and "class rates" assuredly are to some degree descriptive of the proposed change in methodology, particularly among the initiated, *viz.*, health care providers. Yet we are unable to say that section 1396a(a)(30) defines, in plain language, the term "methods and procedures," nor, more importantly, that it

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information" the agency needs to conduct its "final [approval] determination." On the other hand, if the requested "additional information" were a necessary part of the initial submission by the State, and hence of its Plan, Amendment 003 would only have been retroactive to January 1995. *See supra* p. 9.

prescribes the level of detail with which a Plan must describe "methods and procedures." Unlike the Boren Amendment, moreover, section 1396a(a)(30) does not require the State to make "findings" and "assurances," a requirement that arguably might be thought to anticipate a somewhat greater degree of detail and specificity from a Plan's description. As we are unable to discern either a "plain language" meaning or design in section 1396a(a)(30) relating to "the precise question at issue," *Chevron*, 467 U.S. at 842 — i.e., the degree of specificity required in a Plan amendment description of proposed new "methods and procedures" — we next turn to defendants' contention that Congress meant to leave this matter for determination by HCFA, the administering agency.[11]

The second stage in the *Chevron* analysis counsels "a high degree of respect for the agency's role" in administering its enabling statute. *See Strickland*, 48 F.3d at 17 ("The agency need not write a rule that serves the statute in the best or most logical manner; it need only write a rule that flows rationally from a permissible construction of the statute.") *see Lamore* v. *Ives*, 977 F.2d 713, 718 (1st Cir. 1992); *accord Caribbean Petroleum Corp.* v. *United States EPA*, 28 F.3d 232, 234 (1st Cir. 1994); *Cabral* v. *INS*, 15 F.3d 193, 194 (lst Cir. 1994) (agency interpretation "is entitled to deference unless arbitrary, capricious, or manifestly contrary to the statute"). As a general rule, longstanding agency interpretations are entitled to greater deference than more recent ones. *See Bowen* v. *American Hosp. Ass'n*, 476 U.S. 610, 646 n. 34 (1986); *Mayburg* v. *Secretary of Health and Human Servs.*, 740 F.2d 100, 106 (1st Cir. 1984). Further, the more persuasive the rationale for an agency interpretation, the more deference it is due, especially if the statute administered by the agency involves complex questions peculiarly within the

[11] Plaintiffs do not claim that the available legislative history provides useful guidance. *See Strickland*, 48 F.3d at 17 (stating that reviewing court may "examine the legislative history, albeit skeptically, in search of an unmistakable expression of congressional intent").

agency's acquired, technical, or institutional expertise. *Bowen*, 476 U.S. at 646.

Plaintiffs stress that these HCFA regulations describe a State Plan as a "comprehensive written statement," 42 C.F.R. § 430.10 (emphasis added), which must (i) "contain[] all information necessary for HCFA to determine whether the plan [or plan amendment] can be approved to serve as a basis for Federal financial participation (FFP) in the State program," *id.*, and (ii) "describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program," *id.* §447.201. Although these HCFA regulations are not facially inconsistent with section 1396a(a)(30), neither do they expressly resolve the ambiguity inherent in the statute.

Contrary to plaintiffs' assertion, the section 430.10 reference to comprehensiveness accurately describes the State Plan, even under the minimalist interpretation given the term "description" by defendants and HCFA, since we think one cannot rationally contend that a State Plan itself, which must cover no less than *sixty-two* different criteria, *see* 42 U.S.C. § 1396a(a)(1)-(62), is not a "comprehensive" document. For this reason and because HCFA's regulations do not prescribe the level of specificity and comprehensiveness with which "methods and procedures" must be described in a Plan, we must consider the implicit interpretation HCFA has given its own regulations.

Plaintiffs concede that the initial Massachusetts Plan approved by HCFA had been in existence for years, yet it contained only a bare-bones, four-word description of its "methods and procedures." When Massachusetts decided in 1991 to effect a material change in its rate-setting system, from a cost-based to a class-rate system, it reasonably understood that HCFA had interpreted its own implementing regulations to require no *greater* degree of specificity in the Amended Plan's description of reimbursement rates than that provided in the initial Massachusetts Plan, which had gone unchallenged for many years. *See Bowen*, 476 U.S. at 646

n. 34; *Lynch* v. *Dawson*, 820 F.2d 1014, 1020 (9th Cir.1987) (agency's interpretation of regulation is accorded various degrees of deference based on duration and consistency of agency position).

Plaintiffs correctly contend, of course, that this long-standing HCFA interpretation does not foreclose a federal court from determining whether the interpretation an agency has given its own regulations rationally comports with the statutory and regulatory language. Nevertheless, their argument seriously devalues the heightened *Chevron* judicial deference reaffirmed in *Stinson*, which requires the reviewing court to decide whether the agency's interpretation of its own regulation is "*plainly erroneous* or inconsistent with the regulation." *Stinson*, 508 U.S. at 45 (emphasis added).

Since sections 430.10 and 447.201, like section 1396a(a)(30) itself, do not preclude the interpretation implicitly given them by HCFA, we may not second-guess its reasonable policy judgment. *See Bowen*, 476 U.S. at 646; *Massachusetts Fed'n of Nursing Homes* v. *Commonwealth of Mass.*, 772 F.Supp. 31, 39 (D. Mass. 1991) ("The HCFA certainly has more expertise in this complicated area of the law than the courts."). And because plaintiffs have not chosen to join HCFA as a party defendant, *see* 42 U.S.C. § 1396c, we can only infer the rationale for HCFA's longstanding practice from its prior approval of Amendment 003 and its predecessor. Moreover, we find readily apparent a sound policy reason for the HCFA's action.

The Medicaid Act designedly affords States considerable flexibility in administering their respective Medicaid programs, allowing each to devise and modify its Plan in response to prevailing local medical and financial conditions. Once the sixty-two statutory minima in section 1396a(a) are met, each participating State has "wide discretion in administering its local program." *See, e.g., Erie County Geriatric Ctr.* v. *Sullivan*, 952 F.2d 71, 73-74 (3d Cir. 1991); *Lewis* v. *Hegstrom*, 767 F.2d 1371, 1373 (9th Cir. 1985). HCFA's regulatory interpretation — permitting terse descriptions of "methods

and procedures," such as "cost-based" or "class rate" — arguably serves this salutary goal as well. Mandating the inclusion of a detailed formula in the State Plan itself could require a State to file a new Plan amendment each time it needed to alter *any* significant integer in its formula, thereby imposing a cumbersome administrative burden on the State as well as HCFA. Thus, whatever one might think of its wisdom, we cannot say that the implicit policy choice made by HCFA was precluded, either by the statute or HCFA regulations. *See Massachusetts Fed'n of Nursing Homes*, 772 F.Supp. at 39 (noting that HCFA approval of Plan, unless inconsistent with the statute or regulation, implicitly establishes definition of comprehensiveness of the term "methods and procedures" as a matter of law).

Nor do we think the agency decision approving defendants' description of the new class rate system — as one utilizing "fixed fee schedules" — was impermissible, given the original Massachusetts Plan's longstanding description of its provider-cost-based system as a "negotiated fixed fee schedule." HCFA fairly and sensibly reasoned that deletion of the term "negotiated" signified clearly enough that individual providers no longer would be entitled to reimbursement rates set according to their idiosyncratic cost experiences, but would be confined for the most part to across-the-board "fixed" rates established for services rendered in each of the five covered health service classifications. Accordingly, as the longstanding interpretation reflected in the HCFA regulations was not plainly erroneous, defendants were entitled to place reasonable reliance on HCFA's interpretation in preparing and submitting their March 1994 Plan Amendment 003. *Cf. Sekula* v. *FDIC*, 39 F.3d 448, 457 (3d Cir. 1994) ("[A] person 'proceeding in good faith should not be subjected to a trap brought about by an interpretation of a regulation hidden in the bosom of the agency'. . . . [b]ut there is no 'trap' when the agency's interpretation of a regulation is public and long-standing.") (citation omitted).

ii) *Public Notice Under Section 447.205*

Plaintiffs next contend that the HCFA regulations mandate that the public notices issued by the State relating to reimbursement rate changes likewise contain a complete description of the proposed change in methodology. Section 447.205 provides, in pertinent part:

> (a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services. . . .
>
> . . . .
>
> (c) Content of notice. The notice must —
>
> (1) Describe the proposed change in methods and standards;
>
> (2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;
>
> (3) Explain why the agency is changing its methods and standards;
>
> (4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;
>
> (5) Give an address where written comments may be sent and reviewed by the public; and
>
> (6) If there are public hearings, give the location, date and time for hearings or tell how this information may be obtained.

42 C.F.R. § 447.205.

Defendants respond that section 447.205 was complied with because the representative public notice hereinafter quoted explained "why DMA is changing its methods and standards," i.e., "to implement a class rate system by eliminating many of the idiosyncratic adjustments that existed previously [under the cost-based rate setting system]":

> The proposed amendments do not change the existing methodology from July 1, 1992 — December 31, 1992

> except for a provision to allow some eligible providers to request rate reviews based on their cost report, with inflation equal to 1.0. Effective January 1, 1992, the proposed amendments change the structure of the reimbursement methodology to a *class rate system:* establishing new criteria for administrative adjustments; eliminating, among other things, costs beyond agency control, management initiatives, program innovation rate adjustments, and appeals sections of the regulation. It is estimated that the proposed amendments will increase program expenditures by the Department of Public Welfare by approximately $335,000. (Emphasis added.)

For the reasons discussed in Section II.B.2.(a)(i), *supra*, we believe the public notices issued by defendants need not have "describ[ed]" the proposed changes in greater detail than that provided in Plan Amendment 003. Absent a reliable indication to the contrary, we must assume that HCFA construes the term "describe" in section 447.205(c)(1) as it interprets the same term in 42 C.F.R. § 447.201 (providing that Plan amendment "must describe the policy and methods to be used in setting payment rates for each type of service included in the state's Medicaid program"). *Cf. Gustafson* v. *Alloyd Co.*, 115 S.Ct. 1061, 1067 (1995) (noting presumption that a word or phrase used more than once in a statute is intended to have the same meaning); *United States* v. *Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 622 n.4 (1st Cir. 1996).[12]

Plaintiffs complain that interested parties cannot know whether proposed changes in methodology threaten their substantive rights under section 1396a(a)(30) unless the public notice is sufficiently informative. As their name suggests, how-

[12] The only case remotely on point, *see Methodist Hosps.* v. *Indiana Family and Social Servs.*, 860 F.Supp. 1309, 1326-28 (N.D. Ind. 1994), does not undercut HCFA's interpretation. Although the notice involved in that case contained greater detail than these notices, the court found the notice adequate, not inadequate. Consequently, the case is not particularly instructive as to how much less detail might have been considered permissible.

ever, "notice" provisions are neither invariably nor primarily designed to afford exhaustive disclosure, but to alert interested parties that their substantive rights may be affected in a forthcoming public proceeding. *See Mississippi Hosp. Ass'n* v. *Heckler*, 701 F.2d 511, 520 (5th Cir. 1983) (noting that notice is designed to "outline[] the substance of the plan in sufficient detail to allow interested parties to decide how and whether to seek more information on the plan's particular aspects"); *see also* 42 C.F.R. § 447.205(c)(4), (6) (mandating the provision of information to allow interested parties to initiate follow-up after § 447.205 notice). Accordingly, HCFA might reasonably anticipate that the State would provide more detailed information, relating to its methodology, at the public hearings, especially since it is in the State's interest to respond to reasonable requests for further information at the public hearings, if for no other reason than to forfend a future section 1983 action by disgruntled health care providers. *See supra* note 8 (describing potential discovery burdens facing the State in § 1983 action). Thus, HCFA's interpretation cannot be characterized as either plainly erroneous or inconsistent with the Medicaid statute.[13]

Since defendants violated neither procedural requirement established in section 1396a(a)(30), we do not reach defendants' two remaining arguments — i.e., whether the district court erred in refusing to stay its partial summary judgment while Amendment 003 remained pending before HCFA, and whether the district court's declaratory judgment constituted retrospective relief barred by the Eleventh Amendment.[14]

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[13] Since the public notices complied with § 447.205, we need not determine whether plaintiffs acquired *actual* notice during the two and a half years of public consultative hearings and meetings, or whether any such actual notice might excuse the alleged procedural default under § 447.205. *See North Carolina Dep't of Human Resources*, 999 F.2d at 771 (finding that actual notice did not cure procedural default).

[14] Plaintiffs urge us to affirm the district court on another ground. *See Four Corners Serv. Station, Inc.*, 51 F.3d at 314. Before implementing the final class rates in January 1994, defendants failed to consult with the medical care advisory committee (MCAC), appointed by the Massachusetts

b) *Substantive Right to "Equal Access"*

The district court first dismissed plaintiffs' substantive claims on the mistaken ground that plaintiffs had stipulated to their dismissal. Upon reconsideration, the court again dismissed the substantive claims, apparently because its decision on the procedural claims had rendered their resolution unnecessary. Insofar as the district court meant to suggest that defendants' procedural violations from January to October, 1994, were sufficient in themselves to invalidate the final class rates during the January-October 1994 period, without regard to whether the rates violated plaintiffs' substantive "equal access" rights, its dismissal order cannot stand. *See supra* Section II.B.2(a). Since we have concluded that the State was in full procedural compliance, plaintiffs must now adduce evi-

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Medicaid director to represent, *inter alios*, consumer groups, Medicaid recipients, and health care providers specializing in low-income medical services. *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.12(e). We decline plaintiffs' request.

The alleged MCAC violation was first raised in the amended complaint filed in September 1994. The State subsequently reconvened a MCAC, with which it consulted regarding the final rates. The § 431.12(e) case law suggests that States should undertake their MCAC consultations as early in the Plan amendment process as practicable, preferably before any final decision on proposed changes to their reimbursement methodologies. *See Morabito* v. *Blum*, 528 F.Supp. 252, 264 (S.D.N.Y. 1981) (collecting cases). Nonetheless, the Medicaid Act contains no express requirement that a State establish a MCAC, *see* 42 U.S.C. § 1396a(a)(4), an entity entirely the creature of the HCFA implementing regulations. *See Morabito*, 528 F.Supp. at 264. Further, the HCFA regulations prescribe no time bar for the recommended MCAC consultation. Thus, HCFA might reasonably conclude that (1) a State's failure to consult an MCAC, while not the preferred practice, does not constitute a sufficient ground for disapproving a Plan amendment in all circumstances, or (2) MCAC consultation is sufficient as long as it occurs before final HCFA approval of the Plan amendment. Given that the MCAC is a purely advisory body, with no veto power over the State's decisions, *see Burgess* v. *Affleck*, 683 F.2d 596, 600 (1st Cir. 1982) (upholding district court's refusal to enjoin implementation of rates for alleged MCAC violation which was not "egregious"); *cf. Mississippi Hosp. Ass'n, Inc.*, 701 F.2d at 523 (noting court's reluctance to "read more into [§431.12(e)] than is clearly expressed," where "the federal agency whose own regulation is in question has approved the state's actions"), this interpretation is neither plainly erroneous nor inconsistent with § 1396a(a)(4).

dence that (1) the methods and procedures adopted by the State were inadequate to ensure "equal access," or (2) the bottom-line reimbursement figures derived under that methodology were too low to retain health care providers in the Massachusetts Medicaid program. *See supra* note 8. Conversely, if the district court meant to suggest that judicial resolution of plaintiffs' substantive claims was unnecessary because HCFA has already approved Amendment 003 retroactive to January 1, 1994, we cannot agree. HCFA's approval of the State's proposed methods and procedures (i.e., "class rates"), though arguably entitled to the customary level of *Chevron* deference, are not automatically conclusive at the summary judgment stage. Further, the as-yet undeveloped factual record relating to plaintiffs' substantive claims does not reveal HCFA's rationale for approving the substantive terms of defendants' Plan amendment, or whether the final class rates have the actual effect of creating "unequal access" to medical services.

C. *Plaintiffs' Cross-Appeal*

Plaintiffs cross-appeal from the district court rulings that (1) defendants were in compliance with the section 1396a(a)(30) procedural requirements as of November 1, 1994, and (2) defendants did not violate the procedural requirements by instituting their interim and phase-in rates. Although the district court did not reveal the rationale for the latter holding, we presume that it found that the transitional rate methodologies had not effected a "material" or "significant" change from the pre-1991 methodologies. In light of our previous holding, *see supra* Section II.B., we deny plaintiffs' cross-appeal on both fronts.

First, if defendants complied with the putative procedural requirements in filing Amendment 003 and publishing their pre-January 1994 notices, it necessarily follows that their filing of the more detailed Amendment 023 and their post-October 1994 notices likewise would comply with the procedural thresholds prescribed by the HCFA regulations. Second, since we conclude, on the specific facts of this case,

that deference is due HCFA's conclusion that a "description" of "methods and procedures" is adequate as long as it differentiates between a cost-based rate and a class rate system, we affirm the district court's finding that the interim and phase-in rates, which retained some aspects of the pre-1991 "cost-based" or "negotiated" rate systems, did not represent a cognizable change in the methods and procedures such as necessitated a Plan amendment or public notice.

III
CONCLUSION

To the extent section 1396a(a)(30) might create the purported procedural rights advocated by plaintiffs, *Chevron* deference is due HCFA's longstanding statutory and regulative interpretation that a State sufficiently describes its cost-based system as a "fixed negotiated fee schedule," and its proposed class rate system as "fixed fee schedules." We therefore reverse the district court ruling that defendants were in violation of section 1396a(a)(30)'s procedural requirements from January 1 to October 31, 1994. We likewise affirm the two district court rulings challenged in plaintiffs' cross-appeal. Finally, because summary judgment was improvidently granted on plaintiff's procedural claims, the district court ruling that no disposition was necessary on plaintiffs' substantive claims was in error.

Accordingly, the district court judgment for plaintiffs on their procedural claims is vacated and the case is remanded to the district court for further proceedings on plaintiffs' substantive claims, consistent with this opinion.

SO ORDERED. The parties shall bear their own costs.

United States Court of Appeals
For the First Circuit

No. 95-1849

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS, APPELLEES,
v.
BRUCE M. BULLEN, COMMISSIONER OF THE MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE, ET AL.,
DEFENDANTS, APPELLANTS.

No. 95-1999

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS, APPELLANTS,
v.
BRUCE M. BULLEN, COMMISSIONER OF THE MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE, ET AL.,
DEFENDANTS, APPELLEES.

BEFORE
TORRUELLA, *Chief Judge*,
SELYA, CYR, BOUDIN, STAHL AND LYNCH,
Circuit Judges.

ORDER OF THE COURT

Entered: September 12, 1996

The panel of judges that rendered the decision in this case having voted to deny the petition for rehearing and the suggestion for rehearing en banc having been carefully considered by the judges of the Court in regular active service and a

majority of said judges not having voted to order that the appeal be heard or reheard by the Court en banc.

It is ordered that the petition for rehearing and the suggestion for rehearing en banc, be denied.

By The Court:

_____

Clerk

[cc: Ms. Nicholson, Messrs. Mason, Pardee, Smith, Ward, Wilkins]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Civil Action No. 94-10123-NG

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS,
v.
BRUCE M. BULLEN, ET AL.,
DEFENDANTS.

CORRECTED MEMORANDUM AND ORDER

GERTNER, D.J.

I. INTRODUCTION

This is a suit by providers of home health services, challening the rates set by the state under Title XIX of the Social Security Act ("the federal Medicaid Act"). 42 U.S.C. § 1396a *et seq.* On January 1, 1994, the defendants[1] implemented a system for the reimbursement of such services which all parties agree was "new" in several respects. The old approach, "provider cost-based reimbursement,"[2] reimbursed

[1] The defendants are the following: Paula R. Griswold is the Chairperson and a Commissioner of the Massachusetts Rate Setting Commission ("RSC"); Jonelle L. Soelling and Louis I. Freedman are also Commissioners of the RSC. Bruce Bullen is the Commissioner of the Division of Medical Assistance (the "DMA") and formerly Associate Commissioner of the Department of Public Welfare. The RSC is an agency of the Commonwealth which, under M.G.L. c. 6A § 32, is responsible for establishing rates for providers of Medicaid services, subject to review of the DMA. The DMA is the state agency responsible for administering the Massachusetts Medical Assistance Program ("Medicaid Program") established under the federal Medicaid Act, 42 U.S.C. § 1396a et seq. DMA is authorized under M.G.L. c. 118 § 113 to review and to approve or disapprove any changes in rates or in rate methodology proposed by the RSC.

[2] The complaint alleges that prior to the recent changes, each agency had its own rates for the five service categories or disciplines of skilled nursing, occupational therapy, physical therapy, speech therapy and home health aide services. An agency's overhead costs were reimbursed, subject to the

each agency for Medicaid services based on that agency's costs for its most recent fiscal year (adjusted for inflation and subject to certain caps and incentives). The new system, a "class rate" system, selected a single rate, applicable to all agencies throughout the Commonwealth regardless of actual cost for each of the categories of home health services.

Plaintiffs are nine visiting nurse associations[3] seeking declaratory and injunctive relief against the defendants under 42 U.S.C. § 1983 on the grounds that the new class rates — both in terms of how they were determined, the factors taken into account or ignored, and how they have been implemented — did not comply with the federal Medicaid Act and its regulations. The core of the plaintiffs' claim is that the new rates were driven by budgetary constraints, not the statutory factors.[4]

While the state may take budgetary factors into consideration, especially in a time of general belt-tightening, it may not flout the statutory requirements. The defendants' discretion in setting rates is limited by 42 U.S.C. § 1396a(a)(30) (A) [hereinafter "(30)(A)"]. The "Equal Access" provision of (30(A) requires the state defendants to fix the rates at a level consistent with both "efficiency, economy and quality of care" and sufficient to enlist enough providers so that Medicaid recipients have access to services equal to that of the general

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limitation that they could not exceed a certain percentage of the agency's total costs. That percentage, set at the median overhead percentage of agencies statewide, was 42.9 percent for the period 1987 to 1991.

[3] Visiting Nurse Association of North Shore, Inc., Visiting Nurse Association of Boston, South Shore Visiting Nurse and Health Services, Inc., Brockton Visiting Nurse Association, Holyoke Visiting Nurse Association, Inc., VNA Homecare, Inc., Visiting Nurse Association of Greater Lowell, Inc., Visiting Nurse Association of Pioneer Valley, Inc., and Visiting Nurse Association of Central Massachusetts, Inc.

[4] The net effect of the class rate system, the plaintiffs allege, is a substantial drop in the level of reimbursement. They claim that for the majority of the nine agencies, the new class rates would not be sufficient to cover the costs which the agencies incurred even in 1990 or 1991, much less those that they incurred in 1994.

population in that geographic area.[5] If budgetary restraints make it impossible for a state to comply with the statutory standards, so it is argued, they ought not participate in the program. This challenge to the rate setting itself shall be the subject of the trial on the merits.

As a preliminary matter, the plaintiffs raise two procedural issues. They claim that defendants did not give adequate public notice of the rates and the new methodology undergirding them (the "public notice issue"). Nor, they allege, was the new approach spelled out with any specificity in the state plan amendment which the defendants were obliged to submit to the Health Care Financing Administration ("HCFA") for approval by the Secretary of Health and Human Services (the "plan amendment issue").

On March 8, 1994, plaintiffs moved for partial summary judgment based on the public notice and state plan amendment issue. They seek a declaration that 114.3 CMR § 3.00 as revised effective July 1, 1993, implementing the class rates, and its predecessor regulations, implementing the interim rates between July 1, 1991 and June 30, 1993, are void, and an injunction stopping implementation until the state complies with the regulations.[6] Defendants have also moved for partial summary judgment on the same issues.

On March 9, 1994, defendants moved to dismiss on several grounds: (1) that § (30)(A) does not create a right enforceable by these providers; (2) that the complaint fails to allege an actual controversy under § (30)(A); (3) that plaintiffs' chal-

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[5] Section 1396a(30)(A) provides that the state plan must:

> . . . provide such methods and procedures relating to . . . the payment for care and services available under the plan . . . as may be necessary . . . to safeguard against unnecessary utilization of such care and services and to ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

[6] See section IIIB for a description of the history of the rate setting regulations at issue in the instant case.

lenge to certain transitional rates implemented before the new class rates were in effect should be dismissed for want of jurisdiction, and (4) that the complaint should be dismissed for failure to state a "simple, concise and direct" claim in violation for Fed. R. Civ. P. 8.

A hearing was held on all pending motions on May 20, 1994. For the reasons that follow, the Court DENIES the defendants' motion to dismiss with respect to both the July 1, 1993 rates, and the transitional rates. The Court also GRANTS partial summary judgment for the plaintiffs only on the claim that the implementation of the current class rate (embodied in 114.3 CMR § 3.00 as revised effective July 1, 1993) did not comply with either the plan or the notice requirements of the Federal Medicaid Act, and that such implementation should be enjoined pending compliance. Since the Court requires additional briefing on the subject of the validity of the interim rates, it stays enforcement of this Order pending a determination of: (1) The length of time it will take the state to effect compliance; and, (2) Should it be necessary, which regulation (apart from the most recent regulation implementing the class rates as revised July 1, 1993) should be in effect in the interim. *See* Section IV, *infra*.

II. DEFENDANTS' MOTION TO DISMISS

In order to decide the pending motion to dismiss, the Court is obliged to assume that truth of a plaintiffs' well pleaded factual allegations making all reasonable inferences in plaintiffs' favor. *See, Garita Hotel Ltd.* v. *Ponce Federal Bank*, 958 F.2d 15, 17 (1st Cir. 1992).

A. *Whether 42 U.S.C. § 1396a(a)(30)(A) Confers a Right Enforceable Under 42 U.S.C. § 1983.*

1. *Framework for Analysis*

Section 1983 provides a cause of action for persons subject to the "deprivation of any rights, privileges or immunities secured by the Constitution and laws of the United States." The statutory right that the plaintiffs seek to enforce is the right under § 1396a(a)(30)(A) to rates that are consistent with efficiency, economy and quality of care and that are suffi-

cient to ensure that Medicaid recipients have equal access to services.

For the past twenty years, the Supreme Court has reaffirmed the holding that the phrase "and laws" of § 1983 creates a federal cause of action against state officials for violation of rights defined by federal statutes.[7] To be sure, the case law has recognized that not all federal statutes confer rights enforceable under § 1983, a result that could supplant other specific federal enforcement mechanisms, or totally undermine the political compromises that may have given rise to the statute. Much of the litigation has focussed on the issue of identifying statutory rights and the circumstances under which they may be enforced.

In *Golden State Transit Corp.* v. *Los Angeles*, 493 U.S. 103, 106 (1989) and *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), the Supreme Court fashioned a two step analysis. In the first step, the court asks three questions: a) Whether the statutory provision "'was intend[ed] to benefit the putative plaintiff.'" *Wilder* v. *Virginia Hospital Ass'n, supra* at 509 (1990) (quoting *Golden State Transit Corp.* v. *Los Angeles, supra* at 106 (1989)). If so, the provision creates an enforceable right unless it b) "reflects merely a 'congressional preference' for a certain kind of conduct rather than a binding obligation on the governmental unit." *Wilder* v. *Virginia Hospital Ass'n, supra* at 509 (quoting *Pennhurst State School and Hospital* v. *Halderman*, 451 U.S. 1, 19 (1981)). Finally, an

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[7] Although § 1983 was originally enacted to insure equal rights for the newly emancipated slaves, the law referred more generally to rights secured "by the Constitution and laws" without specific reference to race discrimination.

The Court in *Miane* v. *Thiboutot*, 448 U.S. 1 (1980) dealing with the claimed denial of AFDC benefits under the Social Security Act, confirmed what had then been implicit — namely that the Social Security Act and other federal laws could be enforced through this section. *See, Rosado* v. *Wyman*, 397 U.S. 397 (1980); *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990). *See* generally, Sunstein, "Section 1983 and the Private Enforcement of Federal Law," 49 U.Chi. L. Rev. 394 (1982); Rosenblatt, "The Courts, Health Care Reform and the Reconstruction of American Social Legislation." 18 J. Health Policy & Law 439 (1993).

enforceable right will exist unless c) the plaintiff's interest is so "vague and amorphous as to be" "beyond the competence of the judiciary to enforce." *Wilder* v. *Virginia Hospital Ass'n*, *supra* at 509 (quoting *Golden State Transit Corp.* v. *Los Angeles*, *supra* at 106 and *Wright* v. *Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 431-32 (1987)). On this issue, the party seeking to assert the right bears the burden of proof. *See Arkansas Medical Society, Inc.* v. *Reynolds*, 6 F.3d 519, 523 (8th Cir. 1993).

In the second step, the inquiry focuses on whether Congress foreclosed private § 1983 enforcement by providing a comprehensive remedial scheme within the statute. *Golden State Transit Corp.* v. *Los Angeles*, *supra* at 106-107. As to this issue, the defendant bears the burden of proof. *Id.* at 106-107; *Arkansas Medical Society, Inc.* v. *Reynolds*, *supra* at 523. Applying the *Golden State* framework and continuing a tradition of § 1983 enforcement of the Social Security Act,[8] the Supreme Court in *Wilder* held that § 42 U.S.C. § 1396a(a)(13)(A) of the Medicaid Statute (hereinafter the "Boren Amendment" or § 13(A)) created an enforceable right under § 1983.

While the most recent decision of the Supreme Court, *Suter* v. *Artist M.*, ____ U.S. ____ (1992), 112 S.Ct. 1360 (1992),[9] has created some confusion in this area,[10] most courts, have taken the position that *Suter* did not change the *Golden State* analytical framework. In *Albiston* v. *Maine Commissioner of Human Services*, 7 F.3d 258 (1st Cir. 1993), the court held that *Suter*, reflecting concerns that states be aware of their obligations prior to accepting federal funds, heightened the burdens of the plaintiff who sought to enforce a statute

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[8] See note 20 *infra*.

[9] Suter dealt with the provision of Adoption Assistance and Child Welfare Act, 42 U.S.C. §620-628, 670-679a, which required state plans for foster care and adoption services to provide "reasonable efforts" to prevent the removal of a child from his home prior to foster care placement, or to make it possible for a child to return to his home.

[10] See *Evelyn V.* v. *Kings County Hosp. Center*, 819 F.Supp. 183, 192 (E.D. N.Y. 1993).

enacted under the Spending Power. It construed *Suter* as holding that the intent to impose conditions on the grant of federal monies directly on the states must be "demonstrated," not "presumed," and must be delineated unambiguously, i.e., "with sufficient specificity to permit states to exercise their choice [to participate in the statutory scheme] knowingly, cognizant of the consequences of their action." *Albiston* v. *Maine Commissioner of Human Services, supra* at 262-263 (quoting *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981)). Significantly, the *Suter* Court found that the Boren Amendment (which had been at issue in *Wilder)* also met the more rigorous *Suter* test. Section 13(A) of the Medicaid statute, the Court concluded, "actually required the states to adopt reasonable and adequate rates." *Id.* at 1368.[11]

The inquiry here is whether this conclusion applies as well to the neighboring section, § 30(A). In analyzing § 30(A), this Court is not without authoritative guidance — several decisions on point, as well as decisions from the Supreme Court and the circuit courts interpreting analogous provisions of the Social Security Act.

In *Arkansas Medical Society Inc.* v. *Reynolds*, 6 F.3d 519, 523 (8th Cir. 1993), the Eighth Circuit concluded that § 30(A) conferred an enforceable right under § 1983. In effect, the court decided that the template for analysis of § 30(A) of the Medicaid statute was the analogous provision of the Medicaid statute at issue in *Wilder*, (§ 13(A)), and not the entirely different scheme, the Adoption Assistance and Child Welfare Act, at issue in *Suter*.[12] What the *Suter* and *Wilder* courts

[11] The Suter majority's analysis of the Boren Amendment, and its comparison with the Adoption Act provision, applies directly to section 30(A): As in the instant case, the "reasonable" rate requirement at issue in the Boren Amendment was supplemented by other statutory provisions and regulations that "set forth in some detail the factors to be considered in determining the methods for calculating rates. *Id.* at ____, 112 S.Ct. at 1368. By contrast, "[n]o further statutory guidance is found as to how 'reasonable' efforts [to maintain a child or return a child to his home] are to be measured." *Id.*

[12] The Eighth Circuit noted:

> Our analysis in this case is greatly simplified by the Wilder opinion. Although focusing on a different subsection, *Wilder* addressed the

found distinctive about § 13(A) — characteristics that made it enforceable under § 1983 while the adoption statute before the Court in *Suter* was not — apply as well to § 30(A).[13] *See also The Methodist Hospitals, Inc.* v. *Sullivan*, ____ F.Supp. ____ (N.D. Ind.), 1994 WL 363093 (N.D. Ind. 1994) (holding that § 30(A) is enforceable under § 1983); *Sobky* v. *Smoley*, ____ F.Supp. ____ (E.D. Cal. 1994), 1994 WL 271976 (E.D. Cal.) (adopting Eighth Circuit's holding, enforcing § 30(A) under § 1983); *Pennsylvania Association of Home Health Agencies* v. *Snider*, 826 F.Supp. 948 (E.D. Pa. 1993) (holding that home health providers have an enforceable right under § 1983 — although erroneously concluding that §30(A) was part of the Boren Amendment); *Illinois Hospital Association* v. *Edgar*, 765 F.Supp. 1343 (N.D. Ill. 1991) (recognizing hospital's enforceable right under §1983). *But see, Fulkerson* v. *Commissioner, Maine Department of Human Services*, 802 F.Supp. 529, 534 (D. Me. 1992) (holding that recipients may enforce the Equal Access provisions of §30(A) under §1983, while providers may not).

The defendants argue that § 30(A) is significantly different from the statutes found conveying enforceable rights in *Wilder* and *Albiston*. The *Arkansas Medical Society* decision, and others like it, they claim, are not controlling because these courts did not address the issues they raise here. With respect to non-institutional providers, like home health care agencies,[14] they argue that § 30(A), unlike § 13(A) was meant to

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> same statute facing us in this case. *Suter* urges a careful scrutiny of the exact legislation at issue and *Wilder* has already done that. Furthermore, the equal access provision is very analogous to the Boren Amendment examined in *Wilder*, they are similar not only in function but also in the specific language employed.

Arkansas Medical Society, Inc., supra at 525.

[13] One can make a similar comparison with the statute at issue in Albiston: What the First Circuit in *Albiston* found distinctive about the AFDC provision, Title IV-D of the Social Security Act, 42 U.S.C. § 601 *et seq.*, applies as well to § 30(A).

[14] Institutional providers are hospitals and nursing care facilities providing in-patient services. Noninstitutional providers offer in home health services.

authorize limits on spending, "not prop up provider rates at any particular level."[15] For the reasons outlined below, the Court adopts the reasoning of *Wilder*, *Albiston*, and *Arkansas Medical Society*.

2. *Applying the Golden State/Suter framework to § 30A*

On the first issue — whether obligations are imposed directly on participating states — the Eighth Circuit found that the Boren Amendment and § 30(A) were distinguishable. Both are preceded by the same compulsory language — "[a] State plan for medical assistance must . . ." 42 U.S. § 1396a (a). Moreover, 42 U.S.C. § 1396c uses mandatory language in directing the Secretary to stop payments if the plan "no longer complies with the provisions of § 1396a of this title," including the requirements of §30(A). *Arkansas Medical Society Inc.*, *supra* at 526; *Wilder*, 496 U.S. at 512. Cf. *Pennhurst State School and Hospital* v. *Halderman*, 451 U.S. 1 (1981) (refusing to infer congressional intent to condition federal funding on compliance). As the Court observed in *Wilder*, the then Secretary of HHS expressed his intention to withhold funds if the state plan did not comply with the statute or if there is "noncompliance in practice." *See* 42 CFR § 430.05 (1989); *Wilder*, *supra* at p. 512. Rather than the threat to withhold approval of a plan that failed to meet certain general requirements, as in *Suter*, the state's obligations here are buttressed by a categorical threat to stop payments if there is no compliance.[16] Finally, both sections, § 13(A)

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[15] It is the same that the Arkansas Medical Society briefs on appeal did not address this specific argument.

[16] It does not matter than the language cited here is directed to a federal official, the Secretary of HHS. The issue is the extent to which this language defines the state's obligations in "unambiguous" terms. The message could not be clearer: The provisions quoted deny the Secretary the discretion to approve funds for state provisions that do not comply with the law. *See Arkansas Medical Society*, *supra* at 5. Whether the Secretary's enforcement responsibilities parrallel or supplant those of private parties under § 1983 is a separate question under *Golden State*. Given the ample Medicaid case law on this issue (*see* n. 20), defendants do not actually press this position. *See* n. 28.

and § 30(A), define the state's obligation *vis a vis* the providers in similar terms. If the Boren Amendment has been found to do so "unambiguously," giving ample notice to the states as to what its obligations are, then so too does § 30(A).[17]

The fact that § 30(A) confers discretion on the state is not dispositive. As in *Wilder*, the state's discretion is hedged with an obligation to take certain factors into account in exercising it, factors which can be objectively determined.[18] While a number of methodologies may meet the statutory criteria, there are methodologies within the range of statutory discretion and those outside of it.

Likewise, the statute's language is sufficiently clear to meet *Golden State's* concerns about the court's competence to apply the statutory standards. The court is not substituting its judgment for that of the state agency, but simply determining if the agency action was based upon "a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402, 416 (1971).

Finally, the plaintiffs must also demonstrate that they are the intended beneficiaries of the statutory provisions. The Court in *Wilder* concluded that institutional providers were intended beneficiaries of the Boren Amendment because the Amendment concerned their reimbursement. *Wilder, supra* at 510. Since the Equal Access provision of 30(A) also addressed payment for "care and services" provided by non-institutional

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[17] This analysis is identical to the third component of Golden State, i.e., whether the provision at issue is too vague to create an enforceable right. Under *Suter*, the issue was whether the provision conveyed the state's obligations with enough specificity so that it could make a reasoned choice as to whether to participate in the program. Under *Golden State*, the focus was whether the provision was so ambiguous as to be beyond the competence of the court to enforce.

[18] As Justice Brennan noted in Wilder, § 13(A) required that the state "in making its findings . . . judge the reasonableness of the rates against [an] objective benchmark of an 'efficiently and economically operated facility' providing care in compliance with federal and state standards while at the same time ensuring 'reasonable access' to eligible participants." 496 U.S. at 519. Section § 30(A) imposes comparable obligations.

providers, the Eighth Circuit concluded that they "are beneficiaries for the same reasons as were the providers in *Wilder*."[19] *Arkansas Medical Society, supra* at 525. This Court agrees.

The legislative history, and the context in which that history was made, supports the conclusion that Congress created obligations directly enforceable on the states, and did so for the benefit of these providers. When the Equal Access language of §30(A) was adopted in 1989, Congress was not acting on a *tabula rasa*. There was a history of § 1983 enforcement of the Medicaid statute by providers and beneficiaries of which Congress was presumed to be aware.[20] Given this tradition,

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[19] The Arkansas court also cited cases holding that Medicaid service providers could enforce compliance with the Medicaid laws. *See Nebraska Health Care Ass'n* v. *Dunning*, 778 F.2d 1291, 1295 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Oklahome Nursing Home Ass'n* v. *Demps*, 792 F.Supp. 721, 727 (W.D.Okla. 1992).

[20] That history weaves together several strands. First, there is a history of beneficiary suits using § 1983 to enforce aspects of the Social Security Act, beginning with Rosado v. Wyman, 397 U.S. 397 (1970) (enforcing the right to a certain level of benefits as determined by the standard of need under 42 U.S.C. § 602(a)(23)) through *Maine* v. *Thiboutot*, 448 U.S. 1 (1980) (the provision of statutory benefits to recipients is enforceable through § 1983), and more recently *Albiston* v. *Maine Comm'r of Human Services*, 7 F.3d 258 (1st Cir. 1993) (the right to prompt disbursement of child support entitlements is enforceable under § 1983).

There were provider suits under § 1983 seeking reimbursement for reasonable rates, culminating finally in *Wilder*. *See Wilder* v. *Virginia Hospital Ass'n, supra* at 516 n. 14.

Moreover, various procedural amendments to the Act suggested Congress intended that providers be able to sue in federal court for injunctive relief. In response to several states freezing Medicaid payments to health care providers, Congress amended the Act to require states to waive any Eleventh Amendment immunity from suit for violations of the Act. *See* H.R. Rep. No. 94-1122, p. 4 (1976); 121 Cong. Rec. 42259 (1975). The legislative history of those efforts suggest that Congress believed the waiver necessary because the existing means of enforcement — noncompliance procedures instituted by the Secretary or suits for injunctive relief by providers — were inadequate. *Wilder* v. *Virginia Hospital Ass'n, supra* at 517. Because of the opposition generated by statutes requiring that the Secretary withhold Medicaid funds if the State had not executed a waiver of immunity by a given deadline, Congress abandoned the effort. But that repeal was not intended to "be construed as in any way contravening or constraining the

congressional intent and language must be especially clear to support the conclusion that the Congress intended to treat the provisions applicable to these providers differently than it had other beneficiaries under the Act.

In contrast, throughout the legislative history, one finds language suggesting that § 30(A) was intended to confer a benefit on providers. This was particularly the case in 1989 when the Equal Access language, then existing in regulations, 42 C.F.R. 447.204, was included in the statute itself. The House report noted:

> The Committee Bill would codify, with one clarification, the current regulation, 42 C.F.R. 447.204, *requiring* adequate payment levels. Specifically, the Committee bill would *require* that Medicaid payments for all practitioners be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

H.R. Report No. 101-247, 101st Cong., 1st Sess. 390 (1989), reprinted in U.S.C.C.A.N. 2060, 2116 (Italics supplied.)

Likewise, the regulations governing the implementation of the Equal Access provision of 30(A), 42 C.F.R. 447.200, state that:

> This subpart prescribes State Plan requirements for setting payment rates to implement § 1902(a)(30) of the Act, which *requires* that payments for services be consistent with efficiency, economy and quality of care.

(Italics supplied.)

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rights of the providers of Medicaid services, the State Medicaid agencies, or the Department to seek prospective, injunctive relief in a federal or state judicial forum. Neither should the repeal be interpreted as placing constraints on the rights of the parties involved to seek such prospective, injunctive relief." S. Rep. No. 94-1240, at p. 4; *Wilder, supra* at 518.

This history strongly suggests the Congress was never committed to HHS as the primary enforcement arm. Although the opportunity presented itself, Congress never amended the Social Security act to require exclusive HHS enforcement, and shut off private actions. Indeed, the record suggests Congress recognized and approved such actions.

3. *That § 30(A) is Limitation not a Benefit*

Defendants argue that § 30(A) is not enforceable because its purpose was to "limit both utilization and reimbursement" rather than to assure provider rates at any given level. Urging the Court to read the Boren Amendment and § 30(A) in tandem, the defendants argue that the Boren Amendment set an affirmative reimbursement standard for hospitals and nursing homes while § 30(A) was enacted to place an upper limit on that spending. If the purpose of § 30(A) was to limit spending for institutional providers, the defendants argue, then it was also meant to limit spending for non-institutional providers. Furthermore, if its purpose is to limit spending, the defendants claim, then § 30(A) can hardly have been intended to confer a benefit on plaintiffs in this case. They outline the following legislative history:

The Boren Amendment was enacted in 1980, Pub. L. 96-499, §962(a), Stat. 2650, to govern nursing home reimbursement; the following year, it was extended to cover hospitals. Pub. L. 97-35, § 2173, 95 Stat. 808. The operative language, defendants claim,[21] clearly conferred a benefit on institutional providers. From the outset, § 30(A) was enacted to limit reimbursements. Social Security Amendments of 1967, Pub. L. 90-248, § 237. In 1967, the statute required state plans to:

> [P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safe-

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[21] By 1982, § 13(A) provided that the state plan must provide:

> . . . for payment . . . of the hospital services . . . through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards, and *to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.*

The italicized section was enacted by the Boren Amendment. *Wilder, supra* at 507.

> guard against unnecessary utilization of such care and services and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy and quality of care.

In fact, in 1981, Congress amended §30(A) even further, this time eliminating the "reasonable charge" language.[22] Omnibus Budget Reconciliation Act ("OBRA"), Pub. L. 97-35, §2174,[23] Legislative history suggests that the purpose of §2174 was to require that state reimbursement of non-institutional providers be subject to a ceiling, determined in the aggregate rather than provider by provider.[24]

Defendants' position that § 30(A) is a limitation is unaffected by the addition of the "equal access" language to §30(A) in the Omnibus Budget Reconciliation Act of 1989. That language, they claim, was driven largely by Congressional concern that, as a result of low reimbursement levels

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[22] The section then required the state plan to:

> ". . . provide such methods and procedures relating to . . . the payment for [ ] care and services . . . to assure that payments are consistent with efficiency, economy, and quality of care."

[23] This was done in the same year that Congress extended the Boren Amendment to cover hospitals, under §2173.

[24] Defendants quote the Senate report as follows:

> States, in general, determine the reimbursement rate for services, except for in patient hospital care, where they are required to use Medicare's reasonable cost payment system . . . States are required to reimburse skilled nursing facilities and intermediate care facilities at rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. *Generally, for other services, States may establish their own reimbursement levels, provided the amounts do not exceed what would be allowed under Medicare.*
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> • • •
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> Since States would be free under the bill to establish payment rates without reference to Medicare principles of reimbursement, the Secretary would only be expected to compare the aggregate amounts paid to hospitals by Medicaid in applying this limitation. *A similar aggregate test of reasonableness of Medicaid reimbursement would be applicable to physicians.*

Sen. Rep. No. 97-139, at 473, 478 (1981) (Italics supplied.)

and other reasons, inadequate numbers of physicians, especially obstetricians and pediatricians, may choose not to participate in the program in some areas. *See*, H. Rep. No. 101-247 at 390 (1989). While the defendants concede that this provision "could be said to offer some benefit to providers," it characterizes the provision as one intended to benefit recipients rather than providers. The "test of adequacy," they claim, is not "adequacy in relation to any provider's individual costs or to the costs of a hypothetical efficient provider, but instead the availability of covered services to recipients." Defendant's Memorandum in Support of Motion to Dismiss, p. 13. If a provider could show that the level of reimbursement was too low to assure its continued participation, that would not be actionable if other providers could be enlisted to fill the gap.

The reasoning is flawed. First, it may be said that by 1989, with the enactment of the Equal Access provision, § 30(A) had compound purposes, not unusual for legislation that is the product of compromise. In fact, in this respect, § 30(A) was not unlike the Boren Amendment. The Boren Amendment was also designed to limit the excesses of previous rate setting regimes — and *still* the Court found that it conferred an enforceable right.

The Boren Amendment had had two purposes. First, it was a cost containment measure, seeking to replace the previous regime, in which providers were reimbursed for the reasonable cost of services actually provided, which Congress found to be "inherently inflationary." H.R. Rep. No. 158, Vol. 2, 97th Cong., 1st Sess. 279, 293 n. 82 (1981).[25] While

[25] Until 1972, the Medicaid Act required states to reimburse providers for the costs they actually incurred. See *Friedman* v. *Perales*, 668 F.Supp. 216, 222 (S.D. N.Y. 1987) aff'd 841 F.2d 47 (2d Cir. 1988). Between 1972 and 1980, reimbursement rates were to be determined "on a reasonable cost related basis." 42 U.S.C. §1396a(a)(13)(E) (1979); Pub. L. 89-97, § 1902 (13)(B), 79 Stat. 346. At the same time, even the "reasonable cost standard" appeared to be inflationary. The Boren Amendment was passed to go even further to limit costs, to impose standards met by an "efficiently and eco-

the "actual cost" regime provided few incentives to reduce inefficiencies in care, it was hoped that the Boren Amendment would lead states to reduce their reimbursement, thereby forcing providers to control costs. *See* Wing, *American Health Policy in the 1980's*, 36 Case W. Res. L. Rev. 608, 641 (1985-86); Colosi, *Wilder* v. *Virginia Hospital Association*, *supra* at 140-141. It was also intended to increase state discretion to set the methods and standards by which they would calculate reimbursement rates, and make them responsible for conducting studies on the reasonableness of the rates.[26]

At the same time, Congress, concerned lest the reimbursement levels dip too low, required assurances that quality and safety standards would be complied with, and that Medicaid eligible individuals had "reasonable access" to medical care. Federal regulations were specifically promulgated to require states to provide reimbursement at levels necessary to assure access to medical care by Medicaid recipients. 42 C.F.R. § 447.204. Thus, the language which the Court in *Wilder* and *Suter* found to confer enforceable rights, included language of limitation and state discretion.

Second, the defendants minimize the significance of the Equal Access provision in § 30(a), applicable to both institutional and non-institutional providers. The Court in *Wilder* cited to comparable language in the Boren Amendment[27] as part of its rationale for concluding the Amendment conferred an enforceable right. *Wilder*, *supra* at 509. Indeed, the lan-

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nomically operated facility." *See*, Colosi, *Wilder* v. *Virginia Hospital Association*, 12 PACE L. Rev. 139, 140 (1992).

[26] The main purpose of the Boren Amendment was to increase the state's flexibility and discretion in establishing reimbursement methodologies that promote efficient delivery of services, while maintaining federal oversight at the "minimum necessary to assure proper accountability." *See* S. Rep. No. 139, 97th Cong., 1st Sess. at 478 (1981), reprinted in 1981 U.S.C.C.A.N. 744; H.R. Rep. No. 97-158, Vol. 2, p. 293 (1981).

[27] That language in the Boren Amendment was:

> [I]n order to provide care and services in conformity with applicable state and federal laws . . . and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

guage in § 30(A) concerning "equal access" is even stronger than the comparable language in the Boren Amendment ("reasonable access"). While Congress may have been especially concerned with the coverage of obstetric and pediatric care, the fact is that they enacted an Equal Access provision to apply to all categories of covered services.

Furthermore, the fact that the Equal Access provision was intended to benefit the recipients, does not mean that it is not also available to benefit the providers. All of the provisions of the statute are intended to benefit recipients by setting provider rates that will be adequate to the task. The fact did not stand in the way of the Court in *Wilder* or more recently in *The Methodist Hospitals, Inc., supra.* In *The Methodist Hospitals, Inc.*, the district court found that § 30(A)'s Equal Access provision conveyed an affirmative benefit, even as to hospitals, notwithstanding the defendant's claim that it was only intended to cap hospital reimbursements. *See The Methodist Hospitals, supra* at 20.

By the 1989 amendment, § 30(A) functioned relative to non-institutional providers very much like § 13(A) had with respect to institutional providers. It provided for the payment of rates consistent with the same benchmarks, efficiency, economy and quality of care, as in the Boren Amendment, and at a level sufficient to insure equal access. To be sure, there are differences. Nevertheless, the differences between the two are not so substantial as to justify an entirely different interpretation.[28]

B. *Whether the Complaint Alleges an Actual Controversy with Respect to the Right of Recipients to Access to Services under § 30(A).*

Defendants claim that there is no basis for the allegation that the Equal Access component of § 30(A) has been vio-

[28] Defendants have not directly argued that Congress has implemented an administrative enforcement mechanism that would supplant § 1983 enforcement, the second prong of Golden State. They make the argument indirectly — by arguing that this Court should not direct the state to amend its Medicaid plan until HFCA determines that the existing amendment is inadequate. See section IIIC.

lated at this time. They contend that plaintiffs speculate about whether the new rates will a) lead to a dearth of home health services, b) force them to drop out of the program because of the decline in the rates, and c) keep other providers from stepping into the breach so as to assure equal access. This is especially the case, they claim, since the new methodology includes a provision for an adjustment to the rate of any provider if necessary to ensure access to adequate care and services.[29] To the extent that the intended beneficiaries of the statute are the recipients, the issue is not ripe since there is no reason to assume that their equal access to services will falter. To the extent that the intended beneficiaries of the provision are the providers, the issue is not ripe since there is no reason to assume that they would not be successful in securing an adjustment for their own rates, and, failing that, be obliged to drop out of the program.

The issue is not whether the rates set by the defendants will, in fact, have a particular result, failure of equal access, forcing these providers out of the market without replacements. Rather, the issue is whether the rates set by the defendants conformed to particular criteria — whether they took the Equal Access issue and other statutory standards into consideration. That involves an analysis of the rate setting procedures, an analysis which is ripe for decision. The fact that the plaintiffs can appeal their rates, an appeal in which they would bear the burden of establishing the inappropriateness of the rates, is not relevent to the question of whether the

[29] 114.3 CMR 3.07 "The commission shall review and act on a request for a change in rates of payment due to alleged threatened access to service delivery within 60 days after receipt of an application. Providers application must include, without limitation, certification from the Medicaid Division ... that, without an increase in rates, access to services by Medicaid recipients will be jeopardized or that the quality of the service will fall below levels acceptable to the Medicaid Division and required by Title XIX and information regarding the scope and nature of services threatened."

defendants have met their obligations concerning the manner in which the rates were set.[30]

The state setting the rates, and the Secretary of HHS reviewing them, must take certain factors into account — equal access, as well as efficiency, economy and quality of care. As Congress noted in 1989:

> The Committee expects that the Secretary, in determining [based on state plan submissions] whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage. . . .

H.R. Rep. No. 101-247, 101st Cong., 1st Sess. 370 (1989) reprinted in 1989 U.S.C.C.A.N. 2060, 2116.

In addition, quite apart from issues concerning the rate setting mechanisms, the issues that the plaintiffs raise concerning the failure of notice and the adequacy of the state's plan are plainly ripe for review. *See, Oregon Ass'n of Homes for the Aging, Inc.* v. *State Department of Human Resources*, 5 F.3d 1239, 1243 (9th Cir. 1993); *Oklahoma Nursing Home Ass'n Demps*, 792 F.Supp. 721, 727 (W.D. Okla. 1992).

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[30] Other courts have agreed that providers have the right to challenge rate setting methodologies, both institutional and non institutional providers (without expressly addressing the issue of standing). *See, The Methodist Hospital, Inc.* v. *Sullivan, supra; Pennsylvania Home Health Agencies* v. *Snider*, 826 F.Supp. 948 (E.D. Pa. 1993); *Ohio Hospital Association* v. *Ohio Department of Human Services*, 62 Ohio St. 3rd 97 (1991); *Orthopedic Hospital et al.* v. *Kizer*, ____, F.Supp. ____; 1992 WL 345652 (C.D. Cal. 1992) 1992 U.S. Dist LEXIS 21123 (C.D. Ca. 1992); *Illinois Hospital Ass'n* v. *Edgar*, 765 F.Supp. 1343 (N.D. Ill. 1991). Two federal district courts have entertained provider suits without addressing enforceability or standing. *Clark* v. *Kizer*, 758 F.Supp. 572 (E.D. Cal. 1990) modified, 967 F.2d 585 (9th Cir. 1992); *Pennsulvania Ass'n of Home Health Agencies* v. *Snider*, 826 F.Supp. 948 (E.D. Pa. 1993). *Cf. Mary Washington* v. *Fisher*, 635 F.Supp. 891, 902 (E.D. VA. 1985), *Kansas Health Care Assoc.* v. *Kansas Department of Social and Rehabilitation Services*, 958 F.2d 1018, 1022-23 (10th Cir. 1992) (no standing because whether the reimbursement policy is illegal depends on facts specific to each nursing home.)

C. *Whether the Plaintiffs' Motion for Summary Judgment applies to both the Superseding and the Interim Rates.*

Plaintiffs seek to enjoin the implementation of the January 1, 1994 rates and seek a declaratory judgment on the "interim" rates and phase-in rates in effect from July 1, 1993 through December 31, 1993.[31] With respect to the interim and phase-in rates, the defendantgs argue that the plaintiffs' challenge does not satisfy the case or controversy requirements of Article III. Regardless of whether the RSC failed to file a state plan amendment prior to implementing the interim and phase-in rates, the subsequent adoption of new rates removes any "vitality appropriate for resolution . . . of the legal questions presented." Defendants' Opposition to Plaintiffs Motion for Summary Judgment at p. 12 (quoting *Massachusetts Hospital Association* v. *Harris*, 500 F.Supp. 1270, 1280 (D.Mass. 1980).

The *Harris* case does not apply here. In *Harris* the plaintiffs challenged interim rates which had been adopted without filing the appropriate state plan amendment, while the new rates had met all applicable requirements. When the court held that it lacked jurisdiction to review the adoption and implementation of the new rates (on grounds not relevant here), it concluded that a declaration as to the superseded rates would have no effect other than to provide the plaintiff with compensation in a subsequent state proceeding (an end-run around the 11th Amendment).

In the instant case, the Court has denied the defendants' motion to dismiss the complaint. If the Court also rules for the plaintiffs on their summary judgment claims, and enjoins the implementation of the new rates, the interim rates will replace them. *See*, e.g. *Mason Gen. Hosp.* v. *Secretary of Dept. of H.H.S.*, 809 F.2d 1220, 1223 (6th Cir. 1987); *New England Memorial Hospital* v. *Rate Setting Commission*, 394 Mass. 296, 304 (1985). Since the interim rates are presum-

[31] See section IIIB, *infra*.

ably subject to the very same challenges, they do possess, in the words of the court in *Harris*, enough "vitality appropriate for resolution" to satisfy Article III. *Harris, supra* at 1279. *See, Arkansas Medical Society* v. *Reynolds, supra* at 529 (holding that the "defendant's burden is a heavy one" "when attempting to demonstrate that there is no reasonable expectation that the wrong will be repeated.") *See also, Southern Pacific* v. *ICC*, 219 U.S. 498, at 514-515 (allowing a challenge to an Interstate Commerce Commission order that had expired because such order should not be defeated "as they might be, by short term orders, capable of repetition, yet evading review."); *Firefighter's Local* v. *Stotts*, 467 U.S. 561, 568 (1984) (finding a claim for back pay adequate to keep the case from being moot); and *Super Tire Engineering Co.* v. *McCorkle*, 416 U.S. 115 (1974) (finding that so long as the federal court's decision is likely to have some effect in the future, the case should not be dismissed even though the plaintiff's primary injury has passed).[32]

III. Cross Motions For Partial Summary Judgment

A. *Framework for Analysis.*

Plaintiffs have moved for partial summary judgment on the question of whether the Commonwealth has satisfied the requirement that it submit an amendment to the state plan in the event of "[m]aterial changes in state law, organization or policy, or in the state's operation of the Medicaid program" (42 C.F.R. §430.12), and provide "public notice of any significant proposed change in [the state's methods and standards for setting payment rates for services." (42 C.F.R. §447.205(a)). The Commonwealth have moved for partial summary judgment on the same issues.

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[32] The Court also denies the defendants' claim that the complaint should be dismissed for failure to comply with Rule 8, Fed. R. Civ. P. The instant complaint deals with complex issues. The requirements of the Rule must be read with a view to the subject matter of the action. Under the circumstances, the Court finds that the complaint was adequate to meet the requirements of Rule 8.

Summary judgment should be granted where all of the revelant pleadings, viewed in a light most favorable to the non moving party, present no genuine issue of material fact such that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Aponte-Santiago* v. *Lopez Rivera*, 957 F.2d 40, 41 (1st Cir. 1992); *Medina-Munoz* v. *R.J. Reynolds Tobacco Co.*, 896 F.2d 5, 8 (1st Cir. 1990); *Griggs-Ryan* v. *Smith*, 904 F.2d 112, 115 (1st Cir. 1990).

B. *Factual Setting.*

On the plaintiffs' motion for partial summary judgment, the following statutory framework is undisputed:

1. The Medicaid program is a cooperative federal/state program designed to enable the states to furnish medical assistance to eligible low income individuals. The program is jointly financed by the state and federal governments pursuant to the Medicaid Act, but is administered by the state. The agency presently responsible for administering the program is the defendant, DMA. The defendant RSC is responsible for establishing the rates to be paid to the providers of Medicaid services, subject to review by the DMA.

2. While participation in the program is voluntary, once having elected to participate the state must abide by certain statutory requirements. Under 42 C.F.R. § 430.10, it must submit a state Medicaid plan to the federal Health Care Financing Administration (HCFA) which meets the standards of 42 U.S.C. § 1396(a). Section 1396a specifies 58 requirements which a state plan must satisfy in order to be approved by HCFA, including section 30(a). Regulation further specify the details with which the plan must be described. 42 C.F.R. § 430.10; 42 C.F.R. § 447.201(6).

3. In the event of a change in the Medicaid program, defined as a "[m]aterial change[ ] in state law, organization or policy, or in the state's operation of the Medicaid program," the state has two responsibilities, one directed to HCFA and the other to the public. With respect to HCFA, the state must submit a plan amendment to enable HCFA to determine if the plan continues to meet the requirements of

the statute and regulations. With respect to the public, the state is obliged under 42 C.F.R. § 447.205(a) to provide "public notice of any significant proposed change in its methods and standards for setting payment rates for services."

4. Prior to the implementation of the new class rates in January, 1994, the state covered both bases, submitting a plan amendment, as far as the class rates are concerned, and giving formal notice.[33] There is no issue concerning the fact of notice, or the fact of a plan amendment. The only issue of dispute between the parties is whether the state's submissions and notice were adequate.

The following facts concerning issues of notice and the plan amendment are either undisputed, or to the extent there is a dispute, that dispute is resolved in the defendant's favor (for purposes of analyzing plaintiffs' motions). These facts are either taken directly from the defendants' affidavits or, they refer to materials in the plaintiffs' affidavits which the defendants have not challenged.

5. Pre-October, 1991:

The regime prior to October 1, 1991 is spelled out in 114.3 CMR § 3.00 (effective July 1, 1990). During that period of time, the Commonwealth reimbursed each home health agency for Medicaid services based on that agency's costs for its most recent fiscal year,[34] adjusted for inflation and subject to certain caps and productivity incentives (the "provider cost rate reimbursement" system). The result was an elaborate system which set unique rates per agency across the Commonwealth for the five service categories, based largely on their actual costs.[35] Affidavit of Paul A. McNulty, ¶ 7 (hereinafter

[33] This is not the case with respect to the interim rates and phase-in rates. It appears that as to these the state gave notice in a fashion, but never sought to amend the state plan. We address these issues in Section IV, *infra*.

[34] This figure was taken from the cost figure reflected on the agency's cost report prepared in connection with its participation in the Medicare old age assistance program established under title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq*.

[35] The service categories were skilled nursing, occupational therapy, physical therapy, speech therapy and home health aids services.

"McNulty Affidavit"); Affidavit of Susan T. Nicholson (hereinafter "Nicholson Affidavit") ¶ 2. Exhibit A.

6. The July 1991 - June 30, 1993 (the Interim Rate System):

At a public hearing on July 23, 1991, the RSC announced its intention to establish a class rate system at some point in the future. The class rate system was to establish a single rate for each service category for all providers. It was to be based on a "composite of costs an efficient provider would expect to pay for all components within such service." Nicholson Affidavit, Exhibit B, pp 8-9. Its purpose was to contain costs more efficiently than the provider cost rate reimbursement regime had done.[36]

Between that date and January 1, 1994, the RSC implemented a series of measures to phase in the new system by melding the previous approach, which allowed latitude for the different costs among agencies, with more extensive caps, until the class rate system could be fully implemented. The interim rate regime effected in July 1, 1991 "continued to be based on each provider agency's reported costs with tightened rate caps and an added rate relief provision to insure access and quality of care." McNulty Affidavit, ¶ 8. On June 21, 1991, notice of public hearing was sent to all providers describing the changes. The notice consisted of the following:

> The proposed amendments will: 1) change the effective date to July 1, 1991 and replace all other pertinent dates in respect to that date; 2) limit rates to the weighted mean in the respective HSAs; 3) change the inflation factor to 1.040 for 18 months and 2.2 for 12 months; 4) eliminate productivity incentives; 5) add a provision to ensure that access and/or quality is not adversely affected by the above amendments.

[36] At the hearing, Paul McNulty, policy analyst in the Bureau of Ambulatory Care testified as follows: "An agency able to provide services at costs below the class rate will be reimbursed the class rate and profit accordingly. This method will also create incentives for those agencies with higher costs to reduce them to a level below the class rate." Nicholson Affidavit, Exhibit B, p. 9.

Nicholson Affidavit, ¶ 2, Exhibit C. Regulations implementing interim rates were adopted by the Commission. McNulty Affidavit, ¶ 8, Exhibit B.

7. July 1, 1993 - December 31, 1993, Phase-In Rates; January 1, 1994 Class Rates:

A notice of public hearing was filed on September 11, 1992 announcing that new regulations implementing the class rates were being proposed that would "change the structure of the reimbursement methodology." (Nicholson Affidavit ¶ 2, Exhibit F.) The Notice described the new system as follows:

> Establishing new criteria for administrative adjustments; eliminating, among other things, cost beyond agency adjustments, one time transitional adjustments and appeals section of the regulation.

Nicholson Affidavit, Exhibit F. (114.3 CMR § 3.00) New regulations implementing the changes were published. The regulation's summary noted:

> The amendments change the effective date of the regulation. Some definitions have been deleted, changes have been made in reimbursement as follows: Present reimbursement system in effect until June 30, 1993. From July 1, 1993 through December 31, 1993, a phase-in reimbursement methodology will take effect. On January 1, 1994, a class rate system of reimbursement will be implemented.

Nicholson Affidavit, Exhibit H. The proposed regulation itself (issues on May 21, 1993) reaffirmed that there would be two sets of rates: 1) rates applicable during a six month phase-in period extending from July 1, 1993 to December 31, 1993 (§ 3.04(2) and (3), the so called "phase-in" rates;[37] and, 2) rates

[37] The defendants argue that the phase-in rates were not technically class rates, since they allowed variations from provider to provider. Home health rates continued to be based on each provider agency's reported costs, among other things. McNulty Affidavit ¶9. Nicholson Affidavit, Exhibit H. They were amalgams: During the phase-in period an agency whose rate as calculated under the methodology in effect in 1992 falls below the proposed class rates is reimbursed at that rate plus half the difference between the class rate and the calculated rate. An agency whose rate as calculated under the

applicable to the period following January 1, 1994 (§ 3.04(4)). Nicholson Affidavit, Exhibit H.[38]

8. The Plan Amendment:

The State submitted only one amendment to the State Medicaid plan on the issue of rates during the period from 1991 to 1994. The March 8, 1994 amendment, pertaining only to the January 1, 1994 class rates, stated:

> f. Home health care services — fixed fee schedules established by the Rate Setting Commission.

Affidavit of Sharon Gillis (hereinafter "Gillis Affidavit") ¶ 6 with attachment.

C. *Whether the State has Violated the State Plan Amendment Requirements.*

The regulations require that the plan must "contain all information necessary for HCFA to determine whether the plan can be approved as a basis for Federal financial participation (FFP) in the state program" and more particularly that it must "describe the policy and methods to be used in setting payment rates in each type of service included in the state's Medicaid program" including home health services. 42 CFR § 430.10, 447.201(b). Given the detail of the statute, listing the 58 components of the state plan and specifying the kinds of factors which must be taken into account in setting rates (i.e. economy, efficiency, equal access, etc.) and the admonitions of the regulations, it follows that the plan amendment must provide some detail as to whether the statutory standards have been met. Plainly, it did not.

In a footnote, the state argues that the defendants lack the standing to enforce this aspect of the plan. Under the Supreme Court's analysis in *Suter*, they argue, these are program-

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1992 methodology is permitted to exceed the class rate up to a specified upper limit cap.

[38] The regulation states:

> (4) Rates of payment from January 1, 1994. Rates of payment for all eligible providers effective January 1, 1994 shall be the lower of:
> (a) the provider's usual charge to the general public; or
> (b) the schedule of all allowable rates set forth in 114.3 C.M.R. 3.04(4)(b).

matic rights, comparable to the rights the *Suter* court described as a "requirement . . . to ensure . . . that the state have a plan approved by the secretary which contains the [criteria listed in the Adoption Act]." *Suter, supra* at 1367. Unlike the Adoption Act at issue in *Suter*, the right here is the right to have rates set according to certain specific standards and criteria. In addition, that right is integrally related to the right to have those standards and methodologies spelled out in the state plan, and reviewed by the appropriate authorities, a built-in procedure to ensure compliance with the statutory criteria. Likewise the Boren Amendment was not simply the right to rates at a particular level but the rates "that the state finds, and make[s] assurances satisfactory to the secretary" are reasonable and adequate to meet the costs of "efficiently and economically operated facilities." *Wilder, supra* at 501.[39] The right to a rate set according to certain procedures, including certain review procedures in the state plan, was part and parcel of the substantive right sustained in *Wilder* and *Suter*. In analogous cases, a number of courts have held that the right to have the advice and input of a medical care advisory committee under 42 U.S.C. § 1396a(a)(4) is a right enforceable under § 1983 and not simply "programmatic." *See*, e.g., *The Methodist Hospitals, Inc.* v. *Sullivan*, ____ F.Supp. ____ (N.D. Ind. 1994); 1994 WL 363093 (N.D. Ind.) In *Oklahome Nursing Home Ass'n* v. *Demps*, 792 F.Supp. 721, 727 (W.D. Okla. 1992), for example, the court stated that the statute, as defined and

Service Code	Allowable Rates	Service	Service Unit
	$55.76	Nursing Service	per visit
	$18.59	Nursing Office visit	per visit
	$55.85	Physical Therapy	per visit
	$59.60	Speech Therapy	per visit
	$58.22	Occupational Therapy	per visit
	$18.70	Home Health Aide Services	per hour

[39] The fact that the Boren Amendment refers to the making of certain assurances by the state, and § 30(A) does not, is not dispositive. The plaintiffs are entitled to rates according to certain standards and by means of certain detailed procedures set out in the statute and regulation.

implementd by the regulation [the regulation dealing with medical care advisory committees] is an integral part of the plaintiff's enforceable, procedural right to have Medicaid reimbursement rates accompanied by findings and assurances of reasonableness and adequacy. *See also, Morabito* v. *Blum*, 528 F.Supp. 252, 266 (S.D.N.Y. 1981); *Becker* v. *Toia*, 439 F.Supp. 324, 333 (S.D.N.Y. 1977).

Second, the government suggests that the issue of the adequacy of the state plan should be left to HCFA to judge in the first instance. The First Circuit in *Albiston* held that, with respect to compliance with the requirement to prompt disbursement of child support entitlements, the state and Secretary of HHS had parallel obligations. Simply because the secretary also had responsibility to review the plan did not mean that that responsibility was incompatible with the state's separate compliance obligations. *Albiston* v. *Maine Commissioner of Human Rights*, 7 F.3rd at 265 ("... [T]he Secretary's oversight responsibilities are neither incompatible with, nor exclusive of, Congress' imposition upon the participating State of the direct responsibility for fulfilling its plan obligations to the statute's intended beneficiaries.") *See also, Rosado* v. *Wyman*, 397 U.S. 397, 420 (1970) (holding Secretary's authority to withhold funds under § 604 does not preclude private actions to enforce individual rights under Title IV-A of the Social Security Act); *Lynch* v. *Dukakis*, 719 F.2d 504, 511-512 (1st Cir. 1983). The touchstone in *Albiston* was the extent to which the provision imposed a specific obligation directly on the State.[40] Like the Boren Amendment, and the provision at issue in *Albiston*, § 30(A() did so.[41]

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[40] As the court noted in Albiston, *Wilder* suggests that in certain situations an administrative enforcement scheme that imposes clear obligations on the state "may even support the finding of a private right." *Albiston*, 7 F.3d at 269 (quoting *Wilder*, "[i]f the Secretary is entitled to reject a state plan upon concluding that a State's assurances of compliance are unsatisfactory ... a State is on notice ... [of] the concomitant obligation [to beneficiaries] to adopt reasonable and adequate rates." 496 U.S. at 514-515.).

[41] In effect, the state's position is a variant of the second prong of *Golden State*, the argument that enforcement through HCFA preempts enforcement

Finally, the government suggests, that whatever flaws in the state plan amendment relating to the January 1, 1994 rates do not apply to the interim and phase-in rates. The government argues that there was no need to amend the plan since these rate systems, like the pre-June 1991 system, provided for individual cost related rates for home health providers, subject to certain ceilings on reasonable costs. The question is a close one. There is no doubt that these rates were way stations en route to the implementation of the new class rate system which the defendants concede required an amendment to the state plan. At the same time, plaintiffs claim they effected significant reductions in the reimbursement to the plaintiff agencies. In *Oregon Ass'n. of Homes for the Aging, Inc.* v. *State Department of Human Resources*, 5 F.3d 1239 (9thCir. 1993) the court held that the obligation to amend the state plan was triggered by "[a] law that effects a change in payment methods or standards," including one that resulted in "different payment rates," reducing, rather than delaying reimbursement. *Id.* at 1241. *See also*, *Wisconsin Hospital Association* v. *Reivitz*, 820 F.2d 868, 869 (7th Cir. 1987); *Amisub (PSL), Inc.* v. *State of Colorado Department of Social Services*, 879 F.2d 789, 794 (10th Cir. 1989), rev. denied 110 S.Ct. 3212 (1990) ("change in payment rates under the state plan requires the state Medicaid agency to submit the plan amendment to HCFA for approval."); *North Carolina Department of Human Resources* v. *U.S. Department of Health and Human Services*, 999 F.2d 767, 769-770 (4th Cir. 1993) (Powell, Associate Justice (sitting by designation)).

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through private actions under section 1983. As to this issue, the state has the burden of proof. The Supreme Court has underscored the fact that it would not "lightly conclude that Congress intended to preclude reliance on §1983 as a remedy for the deprivation of a federal secured right." *Wright*, 479 U.S. at 423. The state is obliged to demonstrate "by express provision or other specific evidence from the statute itself." *Id.* congressional intent to preclude private enforcement actions. It has not done so. *See e.g.*, note 19 *supra*.

At this juncture, the Court declines to rule on the question of whether the interim rates and/or phase-in rates triggered the obligation to amend the state plan, without further briefing.

D. *Whether the State has Violated the Notice Requirement.*

42 CFR § 447.205(a) provides for notice whenever there is a "significant proposed change in the [state's] methods and standards for setting payment rates for services." Section (d) specifies, among other things, that the notice must sppear in i) a state register similar to the federal register and ii) a newspaper of wide circulation in each city with a population of 50,000 or more. At each stage, the state published its proposed regulations in the CMR and gave notice of its public hearings in the appropriate newspapers — the interim rates, the phase-in rates, and the final class rates. The question is whether these formal notices were adequate to meet the requirements of the regulations.

The regulations specify what the notice must contain, including 1) the "proposed change in methods and standards," and 2) an explanation of "why the agency is changing its methods and standards," 42 C.F.R. § 447.205(c). The plaintiffs challenge the content of the formal notice that the defendants provided. The defendants respond in part by referring to the notice itself but also in part by providing details of the context in which the notice was given:

> Two years of discussions, more than a year of biweekly consultative sessions, a public hearing, numerous telephone calls, correspondence, drafts of the proposed regulation, and finally, the formal published regulation itself.

Defendants' Brief, p. 15. The details are provided in the McNulty Affidavit.

The Court has considerable sympathy for the view that the published notice has to be viewed in a larger setting; namely the actual information communicated from the defendants to the providers, among other interested parties. *Mississippi Hospital Association* v. *Heckler*, 701 F.2d 511, 520 (5th Cir.

1983); *Michigan Hospital Association* v. *Department of Social Services*, 555 F.Supp. 675, 679 (E.D. Michigan 1983). However, the case law suggests that the Court must look only to the four corners of the formal published notice for compliance with § 447.205(b)(1) and (3). *See, The Methodist Hospitals, Inc., supra* at 15-16.

That inquiry in turn leads to the question of the specificity with which the notice must describe a change in "methods and standards." The public notice regulation, and the statutory sections on which they are based, are part and parcel of the right of health care providers to "reasonable and adequate Medicaid reimbursement rates."

As the court noted in *Oklahoma Nursing Home Association* v. *Demps*, 792 F.Supp. at 726:

> The applicable sections of the Act, as well as the regulation, are stated in mandatory and not merely precatory terms. The public notice regulation and the statutory sections upon which the regulation is based are essential parts of, and help to implement, the right of health care providers to reasonable and adequate Medicaid reimbursement rates.

Given the specificity of the statute, the standards which it requires rate setting procedures to meet, and the importance the courts have attached to strict compliance with those standards, the notice must give an indication of whether the standards are being complied with — how the new methodology will meet the statutory criteria. *See, Jennings* v. *Alexander*, 518 F.Supp. 877, 889-890 (M.D. Tenn. 1981).

Looking first to notice of the January 1994 class rates, no provider or recipient reviewing the Commonwealth's formal notice — the notice of proposed regulations in the CMR, the notice of public hearing in the newspapers — would be able to determine if the new rates are likely to comply with the provisions of the statute, specifically the Equal Access and quality provisions. To be sure, most of the cases cited by the plaintiffs deal with situations in which there was a total absence of statutory notice. Only one case, not cited by the

parties as it was decided after oral argument, addresses the issue of adequacy of notice. In *The Methodist Hospitals, Inc.* v. *Sullivan, supra* the court approved notice that provided the methods and standards to be used to formulate the state's new reimbursement methodology in considerably more detail than in the instant case. While it is difficult to compare the notices by any objective measure, the most that can be said is that a provider reviewing the notice in *The Methodist Hospitals, Inc.* would be in a far better situation than the plaintiff providers reviewing the notice of the January 1994 rates to determine whether the statutory standards were followed.

The defendant replies that had the plaintiffs attended the myriad meetings and conferences they would have understood, that, in effect, they received constructive notice of the "methods and standards" regardless of the formal notification. That may well be. Nevertheless, there is no way for the Court to make that determination as a matter of fact based on this record. All that is clear from this record is that the formal notice of the January 1994 rates did not accomplish the statutory objective and that the regulation requires that it do so.

Again the adequacy of notice of the interim and phase-in rates is a closer question which the Court will defer until that issue can be more fully briefed by the parties.

IV. Conclusion

The Court DENIES Defendants' motion to dismiss. The Court GRANTS Plaintiffs' motions for partial summary judgment with respect to the class rates effective on January 1, 1994, and declares that 114.3 CMR § 3.00 (as revised July 1, 1993) is invalid as it applies to those rates. The Court STAYS that judgment, (1) pending a determination of how quickly state compliance can be effected, and (2) pending briefing and resolution of questions concerning the appropriate interim rates.

Corrected Opinion
Issued: October 12, 1994

Nancy Gertner, D.J.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Civil Action No. 94-10123-NG

VISITING NURSE ASSOCIATION OF NORTH SHORE, INC., ET AL.,
PLAINTIFFS,
v.
BRUCE M. BULLEN, ET AL.,
DEFENDANTS.

AMENDED JUDGMENT

GERTNER, D.J.

This action came on for hearing before the Court, Honorable Nancy Gertner, District Judge, presiding, and the issues having been duly heard,

It is Ordered and Adjudged:

1. The Court GRANTS plaintiffs' motion for partial summary judgment and DECLARES that defendants' implementation of class rates on January 1, 1994 (embodied in 114.3 CMR § 3.00 as revised July 1, 1993) was invalid and unlawful because defendants failed to comply with both the public notice requirements and the requirements for an adequate state plan outlined in the Federal Medicaid Act and implementing regulations, including 42 CFR §447.205 (public notice requirements) and 42 CFR §§ 430.10, 430.12(c) and 447.201(b) (state plan requirements). See page 4 of the Court's Memorandum and Order, dated August 18, 1994.

2. On August 18, 1994 the Court stayed entry of its judgment in order to give the defendants an opportunity to determine how quickly they could come into compliance with these requirements, and to obtain further briefing with respect to the plaintiffs' claims that the rates in place before the class rates, the phase-in rates and interim rates, were also invalid.

3. On August 24, 1994 in response to plaintiffs' Motion to Vacate Stay, the Court entered an Order announcing that its stay of judgment would expire on September 30, 1994 if the defendants had not complied with the procedural requirements. At a hearing on that Motion, the Court also indicated that its intention was to enter judgment on September 30, 1994 with respect to the Court's ruling on declaratory relief. See page 4 of the Court's Memorandum and Order, dated August 18, 1994.

4. The Clerk of the Court is directed to enter the above declaratory judgment with respect to the class rates as of September 30, 1994.

5. The Court finds that by continuing to implement the class rates on October 1, 1994 without meeting the procedural requirements, the defendants were in violation of this Court's Order of August 24, 1994.

6. The Court further finds that as of November 1, 1994, defendants were no longer in violation of the Court's Order with respect to the procedural requirements since the defendants submitted a new plan amendment on December 30, 1994, which validated the rates as of November 1, 1994, and published a new public notice. Both the plan and the public notice met the requirements of the law.

7. The Court DENIES plaintiffs' motion for summary judgment with respect to the phase-in-rates and interim rates which were in effect immediately prior to January 1, 1994 and finds that implementation of those rates did not violate the procedural requirements related to notice and state plan requirements.

8. Claims concerning the substantive validity of the phase-in rates and interim rates are dismissed by agreement of the plaintiffs.

9. This Court need not address claims concerning the substantive validity of the class rates implemented by defendants on January 1, 1994, since the Court has found that such rates were invalid by reason of defendants' failure to comply with applicable procedural requirements.

SO ORDERED
Dated: June 30, 1995

NANCY GERTNER, U.S.D.J.

Nancy Gertner, U.S.D.J.

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1396. *Appropriations.*

For purposes of enabling each State, as far as practicable under the conditions in each state, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . there is hereby appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

42 U.S.C. § 1396a. *State plans for medical assistance.*

(a) *Contents.* A State plan for medical assistance must -

. . . .

(4) provide . . . such methods of administration . . . as are found by the Secretary to be necessary for the proper and efficient administration of the Plan [and] for the training and effective use of paid and subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income . . . in the administration of the plan . . . .

. . . .

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in § 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to ensure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan to at least the extent that such care and services are available to the general population in the geographic area.

42 C.F.R. § 430.10. ***The State plan.***

. . . .

(b) The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 C.F.R. § 430.12. ***Submittal of State plans and plan amendments.***

(c) *Plan amendments.*

(1) The plan must provide that it will be amended whenever necessary to reflect-

. . . .

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.

(2) Prompt submittal of amendments is necessary -

(i) So that HCFA can determine whether the plan continues to meet the requirements for approval; and

(ii) To ensure the availability of FFP in accordance with § 430.20.

42 C.F.R. § 431.12. ***Medical care advisory committee.***

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

. . . .

(d) *Committee membership.* The committee must include -
(1) Board certified physicians and other representatives of the health professions who are familiar with the medical needs of low income population groups and with the resources available and required for their care;
(2) Members of consumers' groups, including Medicaid recipients and consumer organizations, such as labor organizations, cooperatives, consumer sponsored prepaid group practice plans, and others; and
(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) *Committee participation.* The committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.

42 C.F.R. § 447.201. *State plan requirements.*

. . . .

(b) The plan must describe the policy and methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

42 C.F.R. § 447.205. *Public notice of changes in Statewide methods and standards for setting payment rates.*

(a) *When notice is required.* Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.

. . . .

(c) *Content of notice.* The notice must -
(1) Describe the proposed change in methods and standards;
(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

(3) Explain why the agency is changing its methods and standards;
(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;
(5) Give an address where written comments may be sent and reviewed by the public; and
(6) If there are public hearings, give the location, date and time for hearings or tell how the information may be obtained.

42 C.F.R. § 447.256. ***Procedures for HCFA action on assurances and State plan amendments.***

. . . .

(c) *Effective date.* A State plan amendment that is approved will become effective not earlier than the first day of the calendar quarter in which an approvable amendment is submitted in accordance with § 430.20 of this chapter and 447.253.